Journal of Prenatal and Perinatal Psychology and Health

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Journal of Prenatal and Perinatal Psychology and Health

JOURNAL OF PRENATAL AND PERINATAL PSYCHOLOGY AND HEALTH publishes findings from the cutting edge of the rapidly growing science of prenatal and perinatal psychology and health. The journal, published quarterly since 1986, is dedicated to the in-depth exploration of the dimension of human reproduction and pregnancy and the mental and emotional development of the unborn and newborn child. It provides a forum for the many disciplines involved, such as psychology, psychiatry, midwifery, nursing, obstetrics, prenatal education, perinatology, pediatrics, law, and ethology. The journal also deals with the numerous ethical and legal dilemmas that are emerging as society reevaluates its attitudes toward adoption and abortion or strives to establish moral positions on high-tech obstetrics and third-party conception. The opinions expressed in articles are those of the authors and do not imply endorsements by APPPAH or the printer, Allen Press, Inc.

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Editorial

I am grateful to have the opportunity to take over the reins as the new Editor-in-Chief of JOPPPAH with this summer issue. I'd like to express my deep appreciation to Jeane Rhodes, who has retired as EIC and has spent many hours training me to step into her large editorial shoes. We are fortunate to have Jeane staying on as Assistant Editor through the end of 2019.

APPPAH's 21st International Congress, is only six months away! We hope to see you November 7-10 in Denver, Colorado. Please check out the wonderful lineup of international presenters and register now at https://birthpsychology.com/2019-congress/welcome.

The summer issue brings you four new articles, two book reviews, and a tribute. Our first article features research from Ignez Carvalho Hartmann, from Heidelberg, Germany. She examines children's preverbal traumas through a psychoanalytic lens, incorporating the use of sand scenes and drawings. Hartmann explains how *psychotraumas* that occur during the pre- and perinatal period and very early childhood have been brought to light and processed with some of her young patients using these expressive therapies. The article also shares several beautiful stories of healing for these children.

Next is a quantitative research article examining the Mothers' Object Relations Scales (MORS), a 44-item questionnaire (as well as a 14-item short-form), created by John Oates of Great Britain & Judit Gervai of Hungary and tested in these two countries. The MORS assesses mothers' perceptions of warmth and invasiveness with their infants, looking for potential challenges in the mother-infant attachment relationship during the first year postpartum.

Ann Caird of Hampshire, United Kingdom, brings us our next article on the importance of conscious conception and early parenting. She also highlights the significance of professionals working with families who have babies and young children, encouraging them to come from a place of presence and objectivity in order to best support these families in their efforts.

In our Sharing Space, Ofra Lubetzky discusses the life and artwork of Vincent van Gogh, through the lens of perinatal loss. Lubetzky shares how Vincent was the first living child born to his mother, who had given birth to a stillborn baby exactly one year prior with the same name. The author examines how this previous loss may have negatively affected the mother's relationship with Vincent, and how the disconnect may have impacted his life and painting.

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We are including a tribute in memory of John Chitty, who passed in February, written by Kate White. John was a teacher of Polarity Therapy and Biodynamic craniosacral therapy in Boulder, CO, an APPPAH conference presenter, and a lecturer in the Monday LIVE series in the Pre- and Perinatal Educator Certificate Program. Kate writes: "We are particularly grateful for John's contributions to understanding babies and the autonomic nervous system. … He often said that babies are the royalty of humanity; they are super-sentient and deserve the best treatment."

Finally, we offer two book reviews about the postpartum time. Alexa Lantiere reviews the book *Maternity Leave: A New Mother's Guide to the First Six Weeks Postpartum* by Cheryl Zauderer. This book offers support for some of the challenging issues that mothers may face following the birth of a baby. Shema Gordon reviews *When Postpartum Packs a Punch: Fighting Back and Finding Joy* by Kristina Cowan. Postpartum mood disorders are addressed in this book and families are given information and tools for support.

As always, we would appreciate your feedback on this journal issue. If you are reading online and would like to share a comment on the issue as a whole, please scroll to the bottom of the journal page on birthpsychology.com and post your comment after the editorial. If you'd like to comment on a particular article, please leave your comment after the article itself. And if you are reading a print copy of the journal, please visit https://birthpsychology.com/journals and select the issue where you'd like to leave your comments. Thank you.

We hope you enjoy this issue and the summer season.

Stephanie Dueger, PhD, LPC
Editor-in-Chief

Forms of Expression of a Preverbal Reality in Child Psychotherapy

Ignez Carvalho Hartmann

Abstract: Preverbal contents need special attention in the therapeutic process, due to their difficult accessibility and the tendency to be actuated in the therapeutic relationship. The author describes how essential steps in intrauterine development are linked to the symbolic representation of the mother-child unit and emphasizes the importance of body-related experiences in curing preverbal traumas. Sand scenes that can be metaphors for the body allow a first expression, at the symbolic level, of these unthinkable contents. The therapist must mirror and contain these messages in order to open new paths of understanding and integration. Several examples drawn from Sandplay© therapy with children who have suffered very early childhood trauma illustrate the importance of the therapist's familiarity with preverbal issues.

Keywords**:** pre- and perinatal psychology, adoption, cellular memory

The body is the place of truth. (Oriental proverb)

The abyss between the intrapsychic reality of the patient and the external reality in the therapeutic relationship may contribute to many misunderstandings. These are expressed, in most cases, in transferential and countertransferential situations, and they can also be experienced in semiconscious, everyday activities. On the other hand, the intrapsychic reality also includes internalized experiences of the pre-verbal phase, which often cannot be expressed in words and consequently could not be symbolized and integrated at the conscious level (Janus, 2013). Through later possibilities, with the differentiation of verbal expression and in the formation and development of perception and self-knowledge—in the functions of the ego: thought, feeling, emotion and intuition, according to

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C.G. Jung—these very archaic *engrams* may appear in the form of memories and physical sensations, feelings, dream images, artistic creations, and also sand scenes, and only then can they become communicable (Reiter, 2002).

The Prenatal Dimension in Psychotherapy

Prenatal development shows us the miracle of life. The most intimate relationship of every human being is the maternal one—the uterus being our first home. If we can expand our perception by focusing on the prenatal child, we would notice that it experiences the maternal relationship in three different ways. First, with very archaic experiences of the "uterine mother," linked to all the experiences of embryological development, in a completely symbiotic relationship. Next, with the experience of childbirth, the child experiences the liberating and extremely complicit mother, in a mutual dance of the most relevant transitional experience of their lives, and which will be implicitly internalized, later becoming the basis of all transitional experiences. Lastly, the mother becomes humanized in the baby's eyes and becomes visible. This is the image of the mother that is closest to our consciousness. This primeval relationship, so diverse in nature, will become the unconscious pattern of all subsequent social bonds. It will be recorded in our implicit memory and in our psychophysical system. Living in the womb becomes the primeval experience of *being in the world*, just as birth reveals the primeval experience of *coming into the world* and, after birth, complete physical and emotional dependence upon the mother or caregiver renders the experience that will be the basis for *being seen and seeing the world* (Janus, 2013).

Today we know the quality of the bond the parents experience, especially the pregnant mother, will be reflected in the quality of the bonds that will be transmitted as a psychological inheritance to the children. The prenatal child in a symbiotic relationship experiences what the pregnant mother experiences, despite being far from able to differentiate, distinguish, and name experiences of fear, shock, disorientation, and anger.

The theoretical and practical knowledge of the theory of object relations, the research with infants, the basis of the theories of bonding (Bowlby, 1969), and the processes of mentalization or *Theory of Mind* (Fonagy, Gergely, Jurist, & Target, 2011) lead us to speculate about the experiences of the prenatal child in their journey before birth and that will come up later in life.

The after-effects of the stressful experiences that precede, accompany, and follow birth were widely researched by specialists in *psychotrauma*.

The supposed *fetal programming* (Van der Bergh, 2012) and the long-term effect of shortcomings during this period have also been widely confirmed.

These extremely precocious psychotraumas are mirrored in physical markings, which translate into more primeval sensorimotor experiences, constituting implicit memory. It is only through the understanding of physical sensations, emotions, internal images, and movement impulses that it is possible to unravel these psychotraumatic episodes. They can be conscientized in two steps: first through the updating of the images and inner feelings; and then differentiating and evaluating them in an emotional and cognitive manner (Janus, 2000). This gradual process of awareness of psychotraumatic episodes can shed light on, for example, how defense mechanisms were established, such as processes of dissociation or identification with the aggressor, that are originally formed due to the need for emotional survival. It is only within an empathic dynamic, considering the most archaic experiences, that it is possible to understand them and finally to transform them.

H.G. Graber (1966) emphasized a very important aspect of the unity of the body ego and its surrounding attributes, such as the umbilical cord and placenta. The body ego noticeably undergoes a transformation between a body that first floats in the amniotic fluid and the body that after birth loses its former attributes through separating the placenta and cutting the umbilical cord (Graber, 1966). In other words, our entire species underwent this experience, thus being the junction between the biological and the archetypal. In that experience, the difference that characterizes the archetypal aspect would be its virtual origin. At the preverbal level, one cannot speak of conflicts because conflicts demand a minimally-mature ego. They are overwhelming sensations and images, which correspond to internalized experiences of very archaic contents called mnemonic records or *imprints* (Wilhelm, 1992). These early relational experiences occur prior to the development of language, such as prenatal, perinatal, and postnatal experiences, and can be revealed through physical sensations in dreams, visions, drawings created unconsciously, paintings that are often abstract, sculptures, etc., as well as in scenes that are unconsciously created in sandboxes.

Implications for psychotherapy

Trauma or deficits in early bonding or relational experiences can later lead people to great difficulty in verbally communicating their inner emotional states. Disconnected from themselves, they are unable to understand, describe, and differentiate these states in themselves or others. Very early traumatic experiences are directly linked to unwanted physical sensations, low self-esteem, or the manifestation of difficult

relationships. Both on a psychological level and on a relational level, these can be experienced or expressed in images and fantasies.

Very early psychotrauma can manifest itself in infants, for example, through excessive crying, apathy or severe agitation, weight loss, gastrointestinal disturbances, lack of sleep, severe irritability, or cognitive disorders, such as a difficulty in the formation of concepts, verbalization, imagination, and low IQ (Schindler, 1982).

Later, the most significant symptoms linked to these very early psychotraumas can be observed in generalized anxiety, fear of the dark with panic attacks, fear of suffocation, suicidal thoughts (especially when the mother intended on having an abortion), and strong regressive desires mixed with a generalized fear of abandonment (Janus, 2013).

The ability to symbolize inner images in sand scenes requires a distinct formation of both the self and the other. It is important to clarify that I am referring to concepts from Fonagy and colleagues' (Fonagy, Gergely, Jurist, & Target, 2011) *Theory of Mind* and not to the theories of C.G. Jung. The basis for this, according to this theory, is the ability to mentalize. The concept of mentalization, according to Fonagy, is based on the ability to perceive emotions, needs, etc., in other people and in oneself as distinct and, at the same time, to be able to perceive oneself through the eyes of the other. This presupposes recognizing one's own affects in a process of self-regulation by updating the experience of one's own symbolic elaboration and then later completing it with verbalization. The process of mentalization begins very early in the mother-infant or caregiver relationship and develops through the sharing of attention and individual perspectives (Fonagy et al. 2011). This deficit is, so to speak, retransmitted unconsciously and in a transgenerational way, with implications in the transmission of the quality of the experienced bond as well as in its unconscious transmission to children (Bolby, 1969). For example, a mother who has an ambivalent bond with her own mother is likely to offer an ambivalent or symbiotic bond to her child. She will struggle with the separation between me and other, that is, between herself and her child.

The mentalization process is mediated *intermentally*, at the mental and neurological level, and progressively establishes itself with the act of thinking, feeling, and doing in everyday life. In psychotherapy, the patient's ability to mentalize is best promoted when the psychotherapist assumes a mental attitude of discernment between the two, focusing on their thoughts, perceptions, and feelings in the present moment and thus providing a secure basis for the facilitation and exploration of the patient's internal states. It is not a question of pointing out or interpreting these inner contents, but of providing this mentalization process, respecting each patient's rhythm and limits.

Basically, the world of imagination provides a good platform for the mentalization process, which can be experienced in the sandplay therapy setting as a space of freedom and protection (Kalff, 1979). Today, we know through neuroscience, that "acting" in the inner images is expressed precisely in the area of the brain that is equivalent to reality.

In this sense, the sand box plays an intermediate role, like a panel showing projections of internalized experiences. The child reenacts his or her reality and this occurs in a symbolic and individualized dimension. The role of the therapist in sand play would be to accompany the child in his or her experiential path, seeking to mirror and support these inner experiences in the interaction with the figures in the sand scenes, in an analogical way (Fonagy et al. 2011).

The German psychoanalyst Dr. L. Janus, who was one of the presidents of the International Society of Prenatal and Perinatal Psychology (ISPPM), states that the ego begins to develop in the mother's womb through extremely early experiences, internalized in the form of *engrams*. These engrams constitute the "affective core," which is subsequently revealed through a symbolic form of physical, visual, and even abstract feelings (Janus, 2000, p.18).

Sandplay therapy, developed by Dora Kalff, is a well established method that can facilitate the approach to a prenatal dimension in psychotherapy (Rhodes, 2006). Sand scenes, as projective forms of a preverbal reality, may surprisingly reveal how these early engrams, resulting from a deficit in the regulation of affects or in the experiences of mirroring, manifest themselves. In order for this *affective core* to be recognized and understood, it is necessary to pay attention to body language, the images expressed in the scene and the verbal expressions resulting from both transferential and descriptive processes of the projections in the sand scenes. The mutual focus on the observation of scenes (in this case, the sandbox as the intermediate object supported by an empathic therapeutic attitude) allows the opening of new windows in the process of mentalization and, consequently, of symbolic elaboration. According to Byington (2008), the symbol is structured in the psyche. Therefore, the symbolic elaboration would result in a psychological restructuring. The role of the therapist is then revealed through the cognitive and emotional function of containing, according to Bion (1963). The patient, in creating his sand scene, updates his traumatic engrams that crystallized in the form of *affective cores*. Faced with this constellation, the therapist recognizes this affective core, performing a symbolic re-interpretation of the contents presented in the sandboxes. This process is extremely important for understanding the patient, especially in the preverbal experiences that, precisely because of their difficult communicability, could not be understood and integrated.

The renowned sandplay psychotherapist, E. Weinrib (1983), writes in her book *Images of the Self* (1983) that Dora Kalff hypothesized at that time that some sand scenes could contain metaphoric images of the body:

> Kalff started to believe that the material elements of *sandplay* acted as a kind of metaphor for the body. She confirmed this hypothesis when patients who were physically ill created pictorial representations of diseased organs in the sand whose shape they did not know. (...) *Sandplay* functioned as a non-verbal mediator between internal impulse and external reality. (p. 42)

The psychotherapist, U. Eschenbach (1985), urges us to be attentive to paintings or scribbles with content that could not be rationally inferred. Some of these expressions might reveal the affective core of prenatal trauma:

> The amplification of a "symbolic *autogram"* of these expressions, on the other hand, makes us recognize a meaning where, in the course of therapeutic dialogue, we can see a clear integration between the movement of unconscious levels to the ego consciousness. What is particularly interesting, in this sense, are the observations of the visual expressions of adults, which in phases of therapeutic regression show contents that recall very early *engrams* from the intrauterine phase, where in verbal analysis there would be no possibility of consciousness. Through the research of the biographical material at this very early stage, the parallels between this biographical material and visual expressions can be seen and made. (p. 94)

The amplification of these symbolic autograms makes us think of the sandplay setting like the sandbox becoming a kind of "symbolic uterus," an alchemic vessel where biographical fabrics are reconstructed that were not "sewn" by time... The symbols of the sand refer us to three aspects of our ternary origin (biological, psychological, and spiritual): the sand itself, for its availability, sustainability, and its indestructible character, crystallizes the archetype of the Great Mother; the sandplay setting also includes the water element, which is experienced sensorially through the wet sand. In almost all creation myths, water appears parallel to the origin of the world and life. Our embryological development takes place in the amniotic environment. In building a sand scene we are, so to speak, reworking our biographical fabrics in a metaphoric way, phylogenetically and ontogenetically.

For prenatal psychology the following questions may be of importance:

1. How can we distiguish projections of early engrams from the patient‘s implicit memory in the sand scenes from the biographical contents of a later phase in life?
2. How is it possible, through the process of transference and countertransference, to enhance the symbolic gaze, in the sense of perceiving a content that refers to a symbolic autogram of preverbal or even prenatal experience, and make way for new empathic paths in the transformation and integration of these previously unspeakable traumatic contents?
3. What would be the implication and direction of the answers to the previous questions in the therapeutic process?
4. In this sense, deepening the questions of the internal state of the pregnant mother would become a relevant aspect in the collection of anamnesis data, both for infantile and adult psychotherapy. How could we deepen this aspect in therapeutic practice?

Here are a few examples of my therapeutic practice that have become, over time, the bastions of these theoretical reflections and this personal research. The names of patients have been changed to preserve their identities. Drawings and sand scene images were used by permission.

Case Studies

The traumatic affective core of premature babies

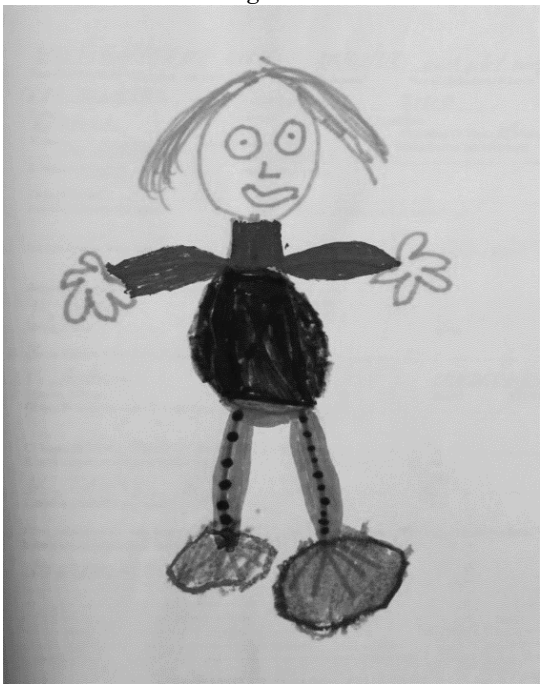
Lea and physical sensations with the rupture of the bond. I met Lea, age six, in my office. The mother describes her little girl as a crybaby. The reason for the visit was a comment from Lea, in which she stated her desire to die. In preschool, she will not let go of the teacher and shows regressive behaviors. Because of gestosis, the pregnancy with Lea had to be interrupted. The parents were on a trip abroad. Lea was born at 32 weeks, weighing 1,200g. The mother described the birth as very traumatic. In her account, I notice that her face is almost motionless and without affection. Because of these symptoms, the parents were very insecure about Lea's schooling and even thought about waiting another year to put her in elementary school. In my countertransferential feelings confused sensations emerge mixed with a strong sense of abandonment. The relationship between Lea and her mother seems extremely entangled and symbiotic. Usually, in the intake history, I first see the child, who is normally accompanied by the mother, although I always stress that the father's presence is indispensable. Lea's mother came to the first session alone.

I met Lea in the second session, accompanied by her mother. She is a frail little blonde girl with funny, colorful glasses. Lea speaks very quietly and constantly watches her mother's face. Without her mother's presence, Lea slowly changes, her voice takes on another volume. When she notices the drawings of other children in my office, she spontaneously tells me that she would also like to paint her self-portrait (figure 1).

Her painting reveals a good cognitive level, but an evident emotional lack. Soon after drawing the outline of her body, she begins to paint her legs, arms, stomach and even her neck blue, correcting the color of her body to black, and finishing it off with small black pearls on both legs that could suggest tears. The face also seems to lack affection, with eyes that look kind of empty, slightly turned to the left.

What strikes me the most, however, is the difference between the size and color of her two feet. Her left foot is almost twice as big as her right one and was painted blue, the color with which she had initially painted her entire body. We know that in symbology the color blue can correspond to the color of water. Was Lea telling me that she still had "a foot in the amniotic environment"?

Figure 1



In the sixth therapy session, she says at the outset, "I need a lot of water today," and uses it extensively until the sandbox becomes a real mire. Then, with her right hand, she opens a path, from left to right, until she reaches the center of the box, emphasizing its blue color. She walks over to the shelves and finds a miniature sleeping baby. Then, she gently places him in a crib in the middle of the sandbox. With pebbles, she surrounds the crib on the right side and says, "The baby is freezing." In order to correct this uncomfortable physical sensation, I immediately grab a tiny yellow paper with which Lea can cover her baby. She smiles with satisfaction and I ask her if the baby feels better now. "No," she replies abruptly, "he needs mommy and daddy." This time she goes to the shelf and chooses the corresponding figures, placing them on the left side of the crib. "Everyone here lives in the water," she adds. The mother figure carries a small child in her arms, the figure of the dad seems to be looking in another direction.

Figure 2

Within a few seconds the expression on her face changes, she looks very pale and whispers to me, "I forgot something..." She takes nine black mosaic tiles from the shelves (despite other colors being available) and creates a black rug beneath the crib. She looks at me sadly: "The baby is hungry, but the mama doesn't know that..."

I was deeply touched by this scene and once again felt undefinable feelings of abandonment in my countertransference.

The composition of this scene with a baby in the crib on a watery surface, Lea's comment about the baby's physical discomfort, feeling very cold (we know that feeling cold is very common in premature babies), doused with the comment that reveals the rupture of the mother-baby bond in a traumatic birth, in which the maternal welcoming of her baby

was not possible in this first experience of "coming into the world," is evidently indicative of a constellation of the affective core of an early engram resulting from gestosis and the emergency delivery.

For me, it is as if Lea could, through projective mechanisms, reveal in this inner image details of an implicit memory of her early emotional bodily experiences and of the rupture of the bond arising from her traumatic birth.

Figure 3

In child psychotherapy, in addition to the quaternary relationship (Jung, 1934) between the conscious and unconscious levels of the therapist and patient, we are also confronted with a third level that overlaps and corresponds to the conscious and unconscious layers of parents (especially the mother, who brings her child to therapy). *Containment* (Bion, 1963) allows the therapist to locate the projected traumatic affective core in the therapeutic content of the unconsciously-created sand scenes. With the complementarity of countertransference relations, the patient's comments and the verification of the biographical data collected in the intake, it is possible to establish new leads for the therapeutic process. After this impacting scene, I decided to intensify the sessions with the mother so that she herself could relive and integrate feelings that had hitherto been repressed as a result of her traumatic first childbirth. We know that, according to Jung (1934), unintegrated feelings in parents produce symptoms in the child. With this intervention, which focused on the monitoring of the traumatic and repressed experiences of the parents, they were able to be more open and empathic in relation to their little

daughter. After this series of therapeutic interventions, there was clearly a change in Lea's behavior, and the relieved and more confident parents opted for Lea's regular schooling.

The traumatic affective core of adopted children

Petra and the affective core of laceration between two mothers. Most adopted children, despite the innate need for bonding, generally exhibit a pronounced mistrust toward adoptive parents and the world at large. In the face of very early traumatic affects experienced in the form of deep emotional wounds, we generally notice specific difficulties in the search of individual identity. We, child psychotherapists, know that every other adopted child exhibits psychological symptoms and behavioral problems. I experienced a very remarkable example of this in my practice, in a psychotherapeutic session with Petra. She had just turned five. The adoptive mother was very concerned that Petra was exhibiting, in addition to primary nocturnal enuresis, extremely aggressive and oppositional behavior. A *disorganized* attachment, typical of children with very early trauma, was observed in the intake.

Petra was adopted when she was one and a half, having come from an orphanage in Nepal to Germany. The decision to adopt came after several unsuccessful attempts at pregnancy. The adoptive mother reports that the child was delivered very quickly to the orphanage, at the request of the caregivers in Nepal. In Germany, the adoption process is very difficult, so many couples seek adoption in orphanages abroad, although the trafficking of children, who are bought in these circumstances, is still an absurdly current practice. The mother recounts this situation with a certain discomfort and negative feeling.

She said that when her daughter arrived in Germany, she was very quiet, almost apathetic. Approximately eight months after she arrived, Petra started to shows symptoms of oppositional behavior, later on enuresis, social difficulties in nursery school, hyperactivity, and attention deficit. The adoptive mother was an only child and was still experiencing a pathological mourning for the loss of her father three years before. At the same time, she was in an extremely delicate situation, being forced to take care of her own mother, who had always been very fragile, almost childish. She recounts that she knew this situation from childhood. I suppose her mother was also traumatized by the circumstances of the war here in Germany, which were transmitted transgenerationally. Faced with this complex family situation, the adoptive mother was emotionally overwhelmed.

In addition to these important details of her history, she reports that she had previously worked in a bank for eight years, where she met her husband, who then became director of this bank. Feeling completely estranged from her talents and ideals, she decided to become a yoga

instructor, which brought her some emotional stability in the face of this disheartening family situation. Thus, we can say that yoga, through the few classes she taught each week, was her source of stabilization. Petra also had a adoptive brother who was two years older, also from Nepal, who displayed hyperactivity problems but who, unlike Petra, was very attached to the mother. The adoption of these children seemed to be an attempt to find a meaning in life.

In my first contact with Petra, I was struck by her liveliness mixed with a somewhat arrogant and domineering manner, which contrasted with her young age. In my office, without even glancing at me, she went straight to the sandboxes.

The sandplay technique, as I practice it, typically begins with a relaxation exercise consisting of body awareness and breathing. Then, we move on to a tactile sensitization of both types of sand (dry and wet), to facilitate, through the transcendent function, the emergence of internal contents and images.

It should be noted that, in symbolic polarity, wet sand offers the possibility of building caves, walls, bridges, etc., while dry sand is more fluid and light. Choosing one sand over the other already offers some criteria in assessing the diagnosis.

At times, children are unable to decide between the two boxes. This is a very important aspect and can only be analyzed deeply if we include the countertransferential and biographical aspects.

In Petra's case, the technical introduction to sandplay was not possible. Faced with this impulsive behavior, I tell Petra that she can try both sands, but not mix them, and then choose one of the boxes to create her picture. She immediately says that she would like to "play" with both of them and starts to create a cave in the wet sand. She then walks over to the shelves to choose her miniature figures and, to my surprise, she starts to create a scene not inside the tray, but on the edge of both trays, which is generally very uncommon.

We might, at first glance, interpret this attitude as an oppositional behavior, yet Petra seems surprisingly concentrated and knows exactly which figures to choose.

The first figure she chooses is a kitten with her baby, which Petra gently puts in a shell. Then, in separate shells, she chooses the father turtle and the mother with a baby turtle, both in a shell, and next to them two turtles without shells that represent the family's older children. It is interesting to note that in the photo we can see this family and the cave built as a "backdrop" and a blue lake.

Figure 4

What immediately caught my attention was the presence of two different mothers and babies, both placed in a shell (first and third shell from left to right).

Symbolically, in a conventional reading, the shell would correspond to the female sex organs. In a symbolic amplification with an emphasis on the biographical aspect of preverbal experiences, we could think metaphorically about the choice of the shell as the object containing mother-baby, as the placental state, in which the uterus plays the role of the alchemical vessel. That is, it is possible to verify the junction of the embryological aspect, coupled with a constellation of the archetype of the Great Mother. The structuring function of the symbol through the unconscious choice of figures gives them the possibility of reconstructing their own story, in the sense of the presence of two very different mothers: the cat and the turtle. At the same time, both mother-babies are represented within an object that, because of its shape, is comforting.

It is interesting to note here that in the arithmetic representation of the Mayan civilization, the number zero is also symbolized by a shell. If we look at the symbology of numbers, we can say that the number zero appeared in the Middle Ages, thus transforming all arithmetic, mirroring a new level of consciousness for all mankind. Archetypically, the number one corresponds to the beginning, that is, to the birth or the visible part of our existence, while the number zero would be the precedent, the invisible part. If we think of biographical fabrics, we could imagine the representation of zero as the invisible part of our history, the miracle of gestation that is not accessible to our eyes. This leads me to rethink the

existing symbolic interpretation and opens new paths in the deepening of the therapeutic practice. To what extent is our symbolic interpretation limited only to what is visually accessible to us?

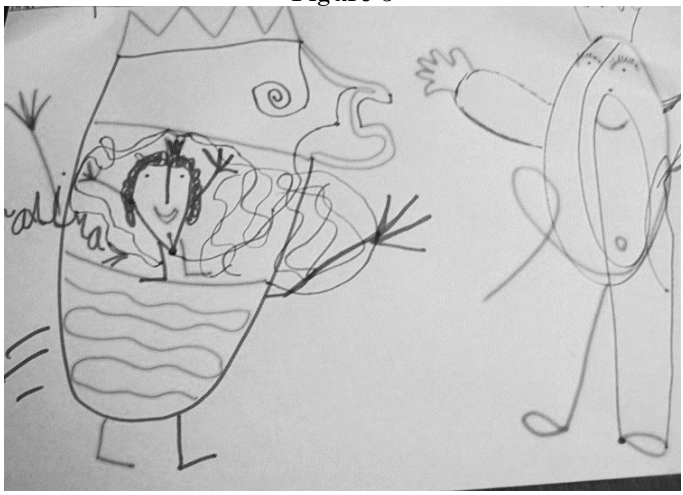
The unusual construction on the edge of the sandboxes made me think of how Petra is unconsciously trying to symbolically relate her own story, which includes the presence of two mothers with babies of such a different nature, and her psycho-emotional laceration between two very different cultures, that is, the Nepalese, which she experienced in an intrauterine form up to a year and a half, and the German thereafter.

In this first phase of therapy, my intention was mainly to achieve a certain emotional stability for both mother and daughter. The therapy sessions took place once a week for Petra and every two weeks for the mother.

During this time, we took the opportunity to write Petra's story, along with the mother, in a childlike way, camouflaging some of the names and scenes of her own story, and arranged an EMDR session (Eye Movement Desensitization and Reprocessing with bilateral stimulation), in which this story could be read by the mother. In this joint session that was carefully planned by me and her mother, Petra is visibly agitated. When the story begins, Petra seems to immediately realize that it is about her and reacts impulsively. She starts to scold me and tries to rip the paper her mother was reading. I remain calm and insist that it be read all the way through, proposing to keep it in a box like a treasure, to be reread in case Petra wants to hear it again.

A few sessions later, Petra begins to spontaneously draw the figure below in which she claims to be the baby in her adoptive mother's belly, side-by-side with the representation of her father. After a few sessions, the mother reports that Petra has become calmer and more affectionate towards her, and that her oppositional behavior, although present, has changed considerably.

Figure 5



The traumatic affective core of abandonment

Sofie and the symbolic images of reconstruction of her own biography. Another interesting example of affective imaging with psychotraumatic contents could be seen in Sofie's therapy. She was referred to my office at the age of seven by a child psychiatrist, with an indication for analytical psychotherapy. Sofie shows hyperactivity and aggression with violent physical attacks against her foster sister who is a year and a half younger. Sofie was four when her sister came into the foster family. In addition to these symptoms, the adoptive mother reports that Sofie has low self-esteem, referring to herself as being dumb and mean.

Sofie arrived at her family as an emergency situation, when she was 13 months old, after having suffered physical abuse from her mother, who was single and psychically very unstable. The neighbors had alerted Child Protection Services. Sofie was immediately taken to a hospital, to await a family that would be responsible for her custody. She arrived at the hospital with several bruises and had to receive nursing care. It took an entire week to find a foster home. Her mother, who decided to adopt her at the age of seven, recounts with tears in her eyes that her daughter, as a baby, was constantly frightened and constantly moved with her little hands "as if to defend herself." To this day she reports that her daughter is very restless and sometimes extremely aggressive.

Sofie was the result of an unwanted pregnancy. Her maternal biological grandparents wanted an abortion, but the biological father opposed it, though he never looked after her later. The biological parents split up during the pregnancy. Faced with this situation, her mother, who

was diagnosed with borderline personality disorder, was emotionally overwhelmed and desperate.

In the intake, her adoptive mother reports that she suffered from depression, above all due to the ardent and unrealizable desire to be a mother. This was the reason why the parents set out to accept the conditions of becoming a foster family, taking in babies in difficult situations.

Both parents had a very difficult childhood. As a child, Sofie's adoptive mother was always very sick and was practically raised by her maternal grandmother. Her relationship with her own mother was described as difficult, never having received affection or care from her mother, who dropped her straight off at her grandmother's house.

From the very start, Sofie is excited about the sandboxes and miniature figures. In the first scene she creates, she already symbolically represents two different mothers. At this time, she still has sporadic contact with her biological mother. These visits are worrisome because soon after she returns home very restless and sad. Feelings of guilt, low self-esteem, and shame about the family situation are typical for children with this history. Through this first scene, it is possible to update the issue that the child is experiencing and verbalize it.

With each step forward in the adoption process, Sofie becomes more restless. From the thirtieth session onward, the miniatures that correspond to the previous maternal figures are compulsively buried and dug up in the sand. The symbolic elaboration can be observed visually. This is a phase of restructuring psychic content.

This phase of therapeutic regression is also expressed in her increasingly less structured drawings and sand scenes, of a clearly preverbal symbolic character. In my office, Sofie becomes a two-year-old child who only wants to play with sand and water. My countertransferential feelings indicate regressive experiences mixed with strongly aggressive impulses, hitherto not experienced in therapy. Above all, comments such as "this has to become a filthy mud," are revealing.

In the following session, she discovers a very flexible wooden snake in the office. She entertains herself by connecting the snake's head to its tail, creating a circle. Then she heads to the box of wet sand and throughout the session, in silence and surprisingly concentrated, reproduces a uroboric shape that she discovered in the snake, modeling it in the sandbox (figure 6) in a central position, which corresponds spatially to the location of the ego-Self vertex (Neumann, 2004).

Figure 6

At the beginning of the 39th session, Sofie wants to play again with the wet sand, and this time she says she will make food for her baby (a doll that is in the therapy room). This scene is very touching: she puts the doll in the rocking chair and says she is going to make a pizza for her baby, with a very maternal expression. Suddenly the play is interrupted (a sign of the traumatic affect) and her facial expression changes. She goes to the sandbox and removes all the sand, depositing it in a bucket that is always next to the box. Then, she fills the sand box only with water. Now, looking at the box, she grabs small handfuls of sand, making it flow in the water and thus forming a small island on the left side of the box, in the first quadrant, symbolically equivalent to the aspect of intuitive and more unconscious function.

On the shelves, she discovers a dog with its puppies and puts them on the island. Then, she places a boat in the water. Sofie is completely absorbed in what she is doing, but suddenly the expression on her face changes. She impulsively grabs a puppy and places it on the other side of the box on its own, facing the wall of the box, almost as if it is cornered. And says, “done.” That is the word that I tell the children to use to let me know that their scene is complete. The scenes are usually created in silence.

Figure 7

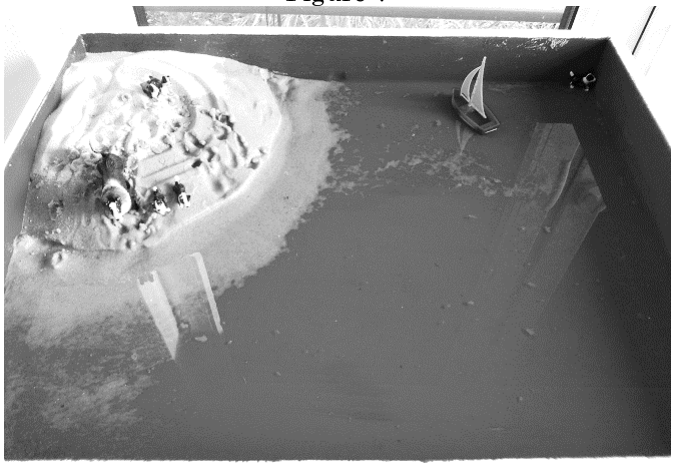


Figure 8

The abrupt change in her actions and the rigid mimicking that accompanies it are revealed as indicators of psychotraumatic affects. The view of the puppy surrounded by water in the farthest corner of the box, from where no movement seems possible, gives me a strong chill and a great sense of isolation. My feelings of countertransference are so physically intense that for a moment they leave me speechless. Soon after, it is as if I see in my imagination and in my associations this abandoned and unwanted fetus that is part of Sofie's story. I wonder, what were the psychic mechanisms that propelled Sofie to build such a scene and thus

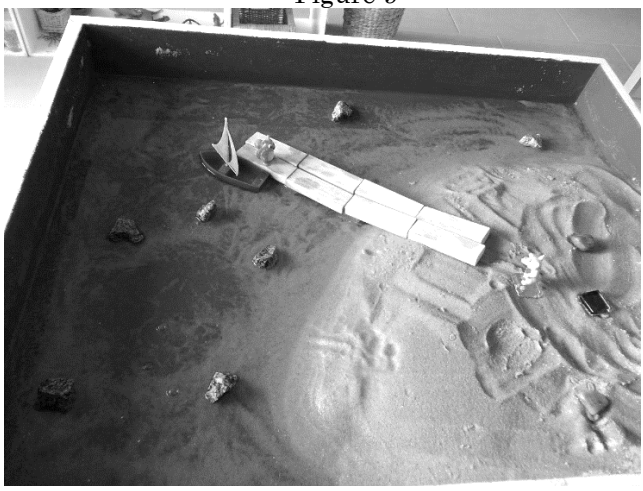
visibly identify herself with this abandoned puppy in the middle of the water and with no possibility of evasion? After a few minutes, I pull myself together and ask Sofie, "What is happening to the puppy?" She says, "The mommy can't find him anymore." Faced with such traumatic content, a verbal intervention becomes essential and I say, "A baby that's alone can't survive without its mommy...he needs his mommy right away! But if mommy can't find him, then we have to find him another mommy." Sofie looks at me without words and confirms with her little head.

A strong sense of abandonment veiled with the illusion of autonomy, that is, negating their own needs, is typical of adopted or orphaned children. The fact that a baby cannot survive without its mother or a caregiver cannot be mentalized by Sofie. This scene clearly shows how the traumatic affect is updated. The verbal intervention interrupting certain pathological patterns of thought is necessary to favor the process of mentalization and self-regulation. About one month later, her adoptive mother informs me that her biological parents agreed to the adoption process. Right at the beginning of the session, Sofie tells me, happily, that she is going to get a new name.

In this session, she creates a sand scene that bears a certain resemblance to the previous one, but with a completely different dynamic: She takes all the sand back out of the box and pours in a lot of water, then forms an island, but this time in the corner diagonally across, in the fourth quadrant, which symbolizes the maternal personal relationship. Instead of a lonely lost puppy, a smiling squirrel appears as a projecting figure of the ego, crossing a bridge towards the island. By his side is an anchored boat (a symbol of autonomy). The personal figure, unlike in the previous traumatic scene, is not alone and abandoned, but rather is awaited by the blue fox that welcomes him. In this scene, the bridge symbol is fundamental: This element of connection indicates that communication has now become possible. From the point of view of prenatal psychology, the bridge could also be seen metaphorically as an umbilical cord that reconnects the fetus with the placenta and, in another context, as the vaginal canal that dilates for the preparation of childbirth. Is this an imagistic way of symbolizing birth on an archetypal level, in view of the adoption process and the presence of another mother? But, above all, it is important to realize that these images bring to light (unlike the previous scene) a form in which Sofie (represented by figure of ego, in this case the squirrel) is no longer isolated, but seen and awaited at the end of the bridge by the maternal figure of the fox, who welcomes her with waving arms, a representation of the strengthening of the bond and the meeting of a basic sense of safety.

At the 46th session, Sofie starts playing the xylophone. Since we usually create many musical stories together, today she seems to want to tell her own story, and begins, "Once upon a time there was a storm, the house was burned, but the firemen quickly arrived, and grandma was also there.“

Figure 9



Her deep wound of abandonment is now symbolically placed on the verbal level, equating the house with the symbol of protection itself, the imaginary representation of the ego. This time, in addition to the rescue (firefighters = hospital nurses) she is no longer alone, grandma (adoptive mother) is also part of the scene. Note that she, in her 50s, could be her grandmother and that she was also raised by her own grandmother.

Sofie is very creative and after this musical introduction she wants to make a clay snowman. In the next session she chooses the color green for her snowman’s eyes (the same color as her eyes) and lovingly finishes it off with a red scarf and a black hat, "for the cold." From here on, this snowman (her self-representation) is almost always used in her scenes; submerged innumerable times in the sand and rediscovered again: It is a phase of psychic restructuring.

In the 81st session, she buries the snowman (the projective figure of the ego) several times and digs it up again until she is satisfied, leaving only his head sticking out. Together, we look at this scene and I ask her how the snowman is feeling now? She answers, "Now he's happy," and leaves the room with a satisfied smile.

Figure 10

Much later, while looking at the picture of this sand image, I discovered that by turning it vertically, a female figure unconsciously emerges: It is possible to clearly see the head, eyes, nose, neck, the hair sticking out to the sides and a body. Sofie put her snowman, unconsciously, right in the middle of the womb, as if restructuring her story on the archetypal level, and as if the eyes of the fetus imaginatively met with the symbol of the Great Mother.

Figure 11

Conclusion

Archetypal images can be understood in a broader sense if we take into account the fact that the prenatal infant is interactive in the uterine environment very early on, and, therefore, has the ability to implicitly internalize his experiences. Today, prenatal psychology confirms the existence of cellular memory. Because the psychotraumas that occur during the pre- and perinatal periods are verbally inaccessible, they are stored as engrams or affective cores, in the form of physical memories, feelings, emotions, dream images, or visual forms and can be accessed through drawings or sand scenes. Considering preverbal reality as an essential part of the biographical fabric opens new windows for understanding patients on a deeper level.

The direct and in-depth questioning of pre- and perinatal experiences in anamnesis and the consideration of transgenerational traumas as a psychological inheritance remind us of the need to extend symbolic interpretations to levels corresponding to the preverbal period. In this way, the sandbox in sandplay therapy emerges as a metahphoric womb space where the traumatic affective core from preverbal memories is directly projected and can be understood symbolically. This approach takes into account biographical elements that were previously verbally inaccessible, and, for this reason, could not be integrated.

I would like to end this paper with a quote from *Wie die Seele entsteht* (*The Origin of the Soul*):

> We can think of human development as a succession of transforming horizons, from the embryo to the fetus and from the newborn to the pre-verbal child, from the schoolchild to the pubescent, and from the young adolescent to adulthood. Each level of development entails its own complex world of experiences that overlap and interact dynamically in the next stages of life. (Janus, 1997, p. 69)

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Mothers' Perceptions of Their Infants

John Oates and Judit Gervai

Abstract: A mother's perceptions of her infant are a core component of her working model of attachment. Interview methods of assessing mothers' perceptions of their infants, while providing detailed and rich information, are time-intensive in administration and analysis. Therefore, a questionnaire measure would be of value for research and healthcare practice. A 44-item questionnaire was developed to investigate the axes along which maternal models are organized. It was predicted that two primary axes, warmth and invasiveness, would be identified, and questionnaire data were collected from mothers in Great Britain and Hungary. The predicted axes were confirmed and a 14-item short-form questionnaire, with good psychometric properties, was derived.

Keywords: attachment, object relations, research and theories, pre- and perinatal psychology

In the perinatal stages of the development of the attachment relationship between mother and infant, a core element is the construction of "the infant in the mother's mind." When the basis for a secure attachment is beginning to develop, a mother will tend to represent her infant's behavior and feelings towards her as predominantly positive in tone, and in consequence will behave in ways that establish positive emotional reciprocity. But this does not always proceed smoothly or on a good trajectory, putting the security of attachment at risk. Infant behavior is often unclear and not easy to read, and a mother who is under stress, depressed, or anxious may perceive her infant in ways that make it more difficult for her to build the foundation for a positive relationship.

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A mother's perceptions of her infant originate partly from the infant's characteristics and behavior, but they are also imbued with projective material deriving from her own inner dynamics (Slade & Cohen, 1996). Her feelings, behavior, and self-identification vis-a-vis her infant involve her internal working model of attachment. Her model of her infant plays a complementary role to her model of herself as mother. A central aspect of how she relates with her young infant is that she interprets her infant's behavior, in terms of its purpose and emotional content, in ways that mesh with the expectations of her working model. A mother attributes thoughts, feelings, and intentionality to her infant, and her own behavior is in turn affected by these attributions (Meares, Penman, Milgrom-Friedman, & Baker, 1982). It has been widely argued that this process commonly involves over-interpretation—that the infant's behavior is treated as if it is filled with agency and emotional content. Indeed, this has been seen by some theorists as a crucial part of an infant's induction into socially defined meanings for behavior (Hinde, 1976) and a key process in the social construction of development (Bruner, 1994; Vygotsky, 1978). Thus, the behavior of an infant crying because of hunger may be interpreted as, "I want feeding, and I want it now, from you (mother)." Further, a mother might also attribute intent to the infant, such as, "My baby is crying now because he wants me to stop what I am doing and give him attention as well as feed him." As a result, a mother might attribute frustration and anger to her infant in such a situation, over and above the simple distress signalled by the cry.

However, infant behavior is deeply ambiguous in terms of its emotional and intentional content, permitting for multiple interpretations. The specific interpretational choice made by a mother is a consequence of an interplay between her internal dynamic and the infant's behavior. Her interpretations reflect her preoccupations, conflicts, and fantasies (Fraiberg, Adelson, & Shapiro, 1983). There is the risk of distorted models arising when the force of a mother's projections dominates her attributions, to the extent that there is little space for reality-testing against actual qualities of the infant. In such circumstances, an observer is likely to see misinterpretations of infant behavior having a major influence on interactions. For example, in Cramer and Stern's classic case-study (Cramer & Stern, 1988), prior to her treatment, the mother interpreted much of her infant's behavior towards her as invasive, hostile, and potentially damaging, and this was seen as stemming from her childhood experiences of invasive, painful medical treatments. Focusing on the source of these distorted interpretations rather than their manifest content, therapy was remarkably effective in reducing the proportion of the infant's behavior that the mother interpreted as invasive. In this case, it was notable that observers also recorded a positive change in the infant's behavior,

evidencing how the mother's model was affecting her infant's behavior as well as her own. Distorted maternal representations have also been associated with child abuse and neglect (Main & Goldwyn, 1984; Milner, 2000; Stratton & Swaffer, 1988), and with postnatal depression (Field, Morrow, & Adelstein, 1993; Murray, Kempton, Woolgar, & Hooper, 1993).

Thinking about the Infant's Mind

Reporting on findings showing a link between maternal reflective functioning and infant attachment, Slade, Grienenberger, Bernbach, Levy, and Locker (2005) proposed that it is a mother's "capacity to understand the nature and function of her own as well as her child's mental states that allows her to create both a physical and psychological experience of comfort and safety for her child" (p. 284). A caregiver's reflective functioning thus leads them to show in their behavior and speech that they are actively thinking about their child's inner world. It has been argued that this can help a child to develop the ability to regulate emotions, which is an important skill in forming positive relationships (Fonagy, Gergely, Jurist, & Target, 2002). There is also evidence of a connection between maternal 'mind-mindedness' and attachment security in the infant (Meins, Fernyhough, Fradley, & Tuckey, 2001). By using the term mind-mindedness, these authors highlight the importance of a mother's capacity to think about the contents of her infant's mind—to attribute thinking and feeling capacities to her infant.

Infant Temperament and Maternal Attributions

Research in the assessment of infant temperament has also contributed to an understanding of the significance of maternal models, in that the correspondence between mothers' reports of their infants' temperament and reports by independent observers is substantially lower than one might expect if mothers' models are solely based on infant characteristics. This finding is often interpreted as due to the influence of maternal attributions (Bates, Freeland, & Lounsbury, 1979; Meares et al., 1982), a view supported by the finding of a relation between mothers' attitudes to childrearing before the birth and judgments of infant temperament made by the same mothers after the birth (Vaughn, Bradley, Joffe, Seifer, & Barglow, 1987). Further support for this view is given by evidence of stability in infant temperament judgements made by mothers during pregnancy and after the birth (Zeanah, Keener, Stewart, & Anders, 1985). It has also been found that differences in mothers' identifications with their fetuses, the initial models of the infant-to-be, are predictive of mothers' models of their infants' emotional and cognitive

capacities at 2-3 months, and also of their infants' levels of engagement with them (Oates, 1998).These early stages in the emergence of what Klein described as a projective identification (Klein, 1946) have been found in other studies to be an indicator of developmentally important aspects of how mothers subsequently relate with their infants one month after the birth (Ammaniti, 1991).

Internal Working Models of the Infant and Attachment Processes

Representations of self and other, and of the dynamic relation between them, are core elements in the development and maintenance of attachments (Bretherton & Munholland, 1999). The development of attachment from the infant's side of the mother-infant relationship entails the construction of an internal working model, ab initio. This model represents the predictability of the action-response dynamic within the dyad. From the mother's side, the attachment relationship brings into play pre-existing psychological structures, activated even before the infant's birth. Differences in mothers' working models during pregnancy have been associated with differences in infant attachment as measured in the Strange Situation (Benoit, Parker, & Zeanah, 1997; Fonagy, Steele, & Steele, 1991). A large body of empirical evidence has shown that infant attachment (Ainsworth, Blehar, Waters, & Wall, 1978) is associated with mothers' internal working models as assessed by the Adult Attachment Interview (Main, Kaplan, & Cassidy, 1985; Fonagy, Steele, Moran, & Steele, 1993; van IJzendoorn, 1995).

Object Relations

In the terms of object relations theory, the infant as an object in the mother's inner world is initially constructed as a nexus of a variety of fantasies, arising from the mother's specific psychodynamics. The relationship that develops with her real infant is the result of a complex interplay between these fantasies and her reality testing against the infant's own characteristics and needs. The mother creates an internal object, a representation of her infant, with which she has a relationship, and her behavior with the "real" infant, the "observed" infant, is suffused with the qualities and dynamics of this internal relation. The effects of this internal relation with the "constructed" infant can be positive for both infant and child, where the internal object is filled with goodness and idealized contents, and the real infant's behavior is represented as loving and warm towards the mother. Or, the internal representation may hold predominantly bad feelings, with the infant then tending to be seen as persecutory, with negative effects for the relationship. The coherence of the internal object can also vary; for example, it may come to hold

conflictual themes, such as wishes for closeness conflicting with fears of being overwhelmed. A dominant theme in all of these is the emotional relationship with the infant. For the mother, how her infant feels towards her is often a most pressing issue in the developing relationship (Kaplan, 1992).

Interview Techniques

Direct assessment of mothers' models of their infants has, to date, commonly been carried out as one of several focal areas of interest within semi-structured interview techniques designed to explore attachment-related representations. Several similar protocols have been documented, each defining a set of topics in which question probes allow the exploration of mothers' representations, wherein representations of their infants form a part: the Representation Interview (R-interview; Cramer, Robert-Tissot, Stern, & Serpa-Rusconi, 1990), the Working Model of the Child Interview (WMCI; Benoit, Zeanah, Parker, & Nicholson, 1997), and the Interview of Maternal Representations during Pregnancy (IRMAG; Ammaniti, Baumgartner, Candelori, & Perucchini, 1992). The Parent Development Interview (PDI; Aber, Slade, Berger, Bresgi, & Kaplan, 1985) includes questions regarding the mother's model of her infant, as well as of herself as a parent and as a partner. The Experiences of Caregiving Interview (ECI; George & Solomon, 1996), an adaptation of the PDI, is designed to activate a parent's working models of self as parent, of the child, and of their relationship. Such methods generate rich data, and have led to substantial new findings, but are also time-intensive to administer and analyze. Used for clinical purposes, the semi-structured nature of these methods offers the advantage to the clinician of being able to explore areas of narrative that suggest the possibility of specific insights into the individual's psychodynamic processes and directions for therapeutic intervention.

A general aim of these interview methods, when used in research, is often to move towards a systematic classification of each case into one of a small number of discrete, mutually-exclusive classes, or to develop interpretive descriptions of representational styles as illustrated in the narratives. While these approaches offer rich primary data and detailed interpretive analyses, and are also useful for diagnostic purposes, they are time-consuming in both the collection and analysis stages. Substantial training is also required by interviewers to ensure consistency of approach and adherence to the interview protocols.

Attachment Styles and Dimensions

Much of the research and theory on attachment is conceptualized within frameworks of categorical classification, for example Ainsworth's

infant attachment classifications (Ainsworth et al., 1978) and the adult attachment styles identified by Main and Goldwyn (1984). Such approaches are not necessarily in opposition to conceptualizations that posit dimensions along which individuals can be located. Underlying typological approaches are often dimensional concepts, such as approach-avoidance, rigidity-flexibility, and regulation-dysregulation, as discussed by Slade (1999). Where the richness of interview data is not required, or where quantitative, scalar data is needed from relatively large samples, there would be significant advantages in having a psychometric instrument that would allow the measurement of mothers' representations on identified axes by the administration of a single, easily-coded questionnaire. Such an instrument could be valuable not only in research, but also in clinical assessment—for example, in primary care screening for disorders of mother-infant relationships.

The Psychometric Approach and Descriptive Axes

Psychometric techniques for assessing relationships and their qualities typically make use of a small number of well-defined axes along which individual responses are scored. The organizing axes of mothers' perceptions of their infants are evidenced when they give narrative accounts of their infants and their experiences with them, much the same way as the Adult Attachment Interview can yield organizing themes from adults' narrative accounts of their attachment-related experiences during their childhoods (Main & Goldwyn, 1984). In dimensional analyses of parent-child related beliefs and behavior, the two most widely found descriptive axes are those of *care* and *control* (Hinde, 1976; Schaefer & Bayley, 1961). The care axis has warmth and coldness as polar opposites, measuring the affective tone of relationships. The control axis has encouragement of autonomy and invasiveness as its polar opposites, measuring the extent to which the relationship is characterized by controlling behaviors. For example, the Parental Bonding Instrument (PBI; Parker, Tupling, & Brown, 1979) assesses on two scales of *parental care* and *overprotection* a person's representation of how they were treated during childhood by their parent(s).

The Aims of the Present Studies

The set of studies reported in this paper was carried out with two main aims. First, to develop a theory-based questionnaire instrument that would have utility in research as a measure of mothers' representations of their infants' feelings towards them, and second, to construct a short form suitable for use also in health practice—for example in primary-care

screening where there is a need for a simple and valid measure of mother-infant relationship quality.

In line with the discussion above, it was predicted that two independent axes, care and control, would be evident as primary organizing dimensions of mothers' models of their infants. If so, this would then support the construction of an instrument yielding two scalar values. In keeping with the theoretical origins of the instrument as described above, it was named the Mothers' Object Relations Scales (MORS).

Strategy

Working towards these aims, the first step was to explore the nature and dimensionality of mothers' perceptions of their infants, by generating a multi-item questionnaire making use of a wide range of descriptors of infants and their behavior, derived from mothers' narrative accounts given in semi-structured interviews. Parallel data was then collected using this questionnaire in two different European countries, Great Britain and Hungary, to seek common axes and at the same time to examine possible cross-cultural variations. Principal components analyses were planned, to identify consistent patterns of response across different subsets of the items, along with other statistical analyses to examine the performance of each item. The second stage was to develop a short form of the questionnaire, based on the statistical analyses, focused on those items that were most sensitive and specific to the axes that were identified.

Methods

Participants

Data were initially gathered from a total of 234 mothers with infants aged between two and six months, covering a range of socio-economic backgrounds and ages, and including both primiparous and multiparous mothers. All participants were white Caucasian, from low-risk general community populations, and without major health problems. In Great Britain, 100 participants were recruited in East London, Milton Keynes, Durham, and Birmingham. In Hungary, 134 participants were recruited in Budapest. Appropriate ethics guidelines and procedures for consent were followed.

Procedure

A set of brief descriptors of infants' feelings, cognitions, and behaviors was generated by examining narrative accounts given by mothers in

previous research (Oates, 1998) and in published material containing such descriptors (Brazelton & Cramer, 1990; Kaplan, 1992; Miller, Rustin, Rustin, & Shuttleworth, 1989; Oakley, 1979). A large number of short descriptors was extracted and assembled, synonymous descriptors were grouped and the most clearly expressed of them were retained. Forty-four items were selected to sample a wide range of aspects of infants as described by mothers, with a focus on those that concerned relations with, and behavior towards, the mother. The items were also chosen to be evocative of projective content from the mother. It was intended to free the mother as much as possible from manifest self-report, by concentrating on descriptors which were explicitly located in the infant, yet allowed the mother's attributions to come through. So, for example, "cares about my feelings" is a descriptor of the infant's emotional world, in relation to the mother, but it is also a latent container for a mother's attributions and needs for emotional reciprocity from her infant.

Items were presented with a six-point Likert scale response format, defined as "how often the following are true of your baby" with response points "always," "very often," "quite often," "sometimes," "rarely," and "never." The items were translated into Hungarian, back translated for accuracy, and piloted in both countries, with minor changes to wording to improve clarity. The full set of items as included in the final version is shown in Appendix 1. After further piloting to confirm the acceptability of the items and the ease of completion of the questionnaire, the final version was administered to mothers of infants in Great Britain and Hungary.

Method of Analysis

The data from both countries were combined and the item score distributions were examined to identify highly-skewed, non-discriminating items. Seven items (items numbered 4, 8, 19, 30, 38, 40 and 42; see Appendix 1) were eliminated on this basis at this stage, leaving data from 37 items.

The reduced British and Hungarian datasets were then analyzed separately, to identify primary axes underlying mothers' responses to the questionnaire. Using SPSS, components were extracted using Principal Components Analysis (PCA), with Varimax rotation.

Next, the datasets were merged and a constrained PCA was carried out to identify the common latent structure, and a hierarchical cluster analysis of the item scores (Ward's method on squared Euclidean distances) was carried out to confirm the componential structure.

Results

British Dataset

After applying the extraction method and procedure described above, examination of the scree plot suggested that a four-component solution was appropriate, with a discontinuity after the fourth component. An examination of the high-loading items associated with the first four extracted components suggested that they described meaningful and differentiable axes. The sets of items associated with the five subsequent components did not show any such obvious coherence, nor did they explain large amounts of variance. This solution explained a total of 46.8% of the data variance. The high loading items on each of these four components are shown in Table 1. The component that explained the largest proportion of variance contained high loading items that were clearly describing a "warmth" dimension. The second component also contained conceptually coherent items describing a dimension that could be labelled as "disturbance of the mother." The third component contained high loading items on the theme of emotional demands on the mother. Items loading high on the fourth component had connotations of emotional withdrawal by the infant. Conceptually, the latter three components appeared to represent elements of the general construct of "invasion-withdrawal."

Component	% of variance	Highest loading items (score weight)
Warmth	17.0	is affectionate towards me (.84) laughs (.81) smiles at me (.81) 'talks' to me (.79) likes doing things with me (.75)
Disturbance	11.8	annoys me (.83) winds me up (.72) irritates me (.65) stirs me up (.62) is exhausting (.58)
Emotional demands	9.1	wants too much cuddling (.81) wants too much attention (.77) is too dependent on me (.53) knows how to get his /her own way (.52)

Withdrawal	8.8	gets moody (.69) is unpredictable (.57) cries for no obvious reason (.56) gets sad (.54) is perfect (-.54)

Table 1. Principal Components in the British Dataset (four-factor solution).

Three- and two-factor solutions for the British data showed the "invasion" components progressively combining, while the "warmth" component remained independent. A constrained two-factor solution explained 34.5% of the data variance, with 17.4% explained by the invasion factor and 17.1% by the warmth factor.

Hungarian Dataset

When the same analysis was applied to the Hungarian data, three of the four resulting components were similar to the first three factors in the British dataset, although their relative contributions to explained variance were more equal to each other, as can be seen from Table 2.

Table 2. Principal Components in the Hungarian Dataset (four-factor solution).

Component	% of variance	Highest loading items (score weight)
Power	11.8	is stubborn (.85) is strong willed (.82) is demanding (.77) knows how to get his/her own way (.53)
Disturbance	11.6	winds me up (.77) annoys me (.75) irritates me (.67)
Warmth	11.2	is affectionate towards me (.74) laughs (.69) smiles at me (.70) 'talks' to me (.65) likes to please me (.64)
Emotional demands	7.1	is too dependent on me (.80) wants too much attention (.72) wants too much cuddling (.69)

The three-factor solution for the Hungarian data showed a similar pattern to that in the British data, with a warmth factor first in order of explained variance, a combined power and disturbance factor coming

second, followed by an emotional demands factor. The two-factor solutions from each country's datasets were, however, the most similar. The Hungarian two-factor solution explained 28.6% of the variance, with the invasion factor explaining 14.8% and the warmth factor explaining 13.8%. The factors had very similar item loadings to the British two-factor solution.

A Two-Factor Solution for the Combined Dataset

Given the similarity in results for the two datasets, they were then combined and re-analyzed together to yield a common factor structure. Since the two-factor solutions for each country showed the highest level of similarity, the solution was constrained to two components: a clear invasion factor emerging that explained 29.2% of the variance, and a distinct warmth factor emerging that explained 17.7% of the variance. The seven highest loading items on each of these two components are given in Table 3. All of these loadings were high—at .7 or greater.

Table 3. Principal Components in the Combined Dataset (two-factor solution).

Component	% of variance	Highest loading items (score weight)
Invasion	29.2	gets moody (.80) wants too much attention (.78) irritates me (.75) winds me up (.75) dominates me (.73) cries for no obvious reason (.72) annoys me (.71)
Warmth	17.7	is affectionate towards me (.87) 'talks' to me (.80) likes doing things with me (.77) smiles at me (.76) laughs (.75) likes to please me (.74) likes me (.66)

Cluster Analysis: Combined Dataset

Two clear, well-distinguished clusters were identified from the analysis of the combined dataset, one including all the high-loading "warmth" items and the other including all the high-loading invasion

items. The "emotional demands" items were contained within a distinct sub-cluster, as were the "disturbance" items. Although the "power" items were spread across different sub-clusters, they were still contained within the main invasiveness cluster.

Test-Retest Reliability

The 44-item questionnaire was administered to a new, healthy, Hungarian, low risk, white Caucasian community sample of 36 mothers, with infants aged between six and 12 months, on two occasions, with a two- to three-week interval. After excluding the seven non-discriminating items, the remaining 37 items showed a median reliability coefficient of r = .61 with a range from .91 - .11. It is noteworthy that the high reliabilities were found for the invasion-related items, and the lower were for the warmth-related items.

Evidence for Organizing Axes

These results are strong evidence for the existence of a general, primary axis that organizes mothers' perceptions of their infants, concerned with aspects of infants' emotions towards the mothers. In both Britain and Hungary, items such as "is affectionate towards me" and "likes doing things with me" are responded to consistently by mothers, showing that these items are meaningful to them as descriptors of their infants. In both countries, a principal component containing items in this area captures a significant proportion of the variance in the responses of different mothers. This result is consistent with our prediction that a "care" axis, with warmth and coldness as polar opposites, concerned with the emotional tone of the infant's feelings, would be one of the primary dimensions revealed in these data. It is noteworthy that the high loading items on this axis predominantly reflect perceptions of the infant's feelings specifically towards the mother, lending further support to the view that perceptions of the infant are constructed in part through the mother's projective wishes and needs for herself.

The prediction was supported that another primary axis would be concerned with issues of perceived control in the mother-infant relationship, in that items tapping such issues did indeed emerge as having high loadings on components. The two-factor solutions for the two datasets, both separately and for the combined set, consistently showed items associated with perceptions of invasiveness loading highly on one factor, alongside the clearly present warmth factor. Three and four-factor solutions also showed conceptually coherent groupings of items, suggesting that the general invasion axis could also be seen as divisible into a "disturbance of the mother" axis and an "emotional demands" axis,

based on the three-factor solution. The four-factor solutions differed between the countries, with items suggesting a "power" axis loading on a factor in the Hungarian data and items suggesting an "emotional withdrawal" grouping in the British data.

Item reliability coefficients were generally adequate, being high for invasion items. Some warmth items showed low reliability, perhaps reflecting in part variations in infants' affective states across the test-retest interval.

Derivation of the Short Form of MORS

These results were sufficiently encouraging to move to deriving a short-form version of the scales, based on the 14 high-loading items from the two-factor solution—the total of the scores on seven items giving a value on the "invasion" dimension and the other seven items' total scores contributing to a "warmth" value. This MORS short form (MORS-SF) set of 14 items is shown above in Table 3.

An adequate psychometric instrument should be internally consistent, should have clear face validity, and multiple axes should be sufficiently independent. The items to which responses are made should show explicit, clear, and unambiguous relations to the theoretical construct(s) that the instrument purports to measure and the responses to different items that purport to measure the same construct should be closely correlated, both statistically and in their manifest meaning.

Internal Consistency and Item Contributions

The finding of common structure in the Hungarian and British data is a first confirmation of the validity of the underlying two-axis structure of the instrument. Further support is given by the manifest semantic relation of the high loading items on these axes to the dimensions of invasion and warmth commonly found as organizing axes of representations of relationships between parents and children, and between adults (Schaefer, 1965; Parker et al., 1979).

Each MORS-SF item loads positively on its associated axis, hence sum scores were used for all calculations: thus increasing values on the Warmth axis represent increasing perceived infant warmth, and increasing Invasion axis values indicate increasing perceived invasiveness. Cronbach's alpha values for both the Invasion and Warmth scales were .90, indicating high internal consistency.

Face Validity

The items comprising the short-form were all derived from statements made spontaneously by mothers when describing their infants. They were then extensively piloted and mothers found them unambiguous and easy to respond to. It is evident that each item captures an element of maternal interpretation of infant experience and behavior and hence is tapping into the content of an internal working model rather than simply capturing surface observations. This latter point is supported by the fact that most of the 14 items are clearly concerned with the infant in relation to the mother, rather than just the infant as an isolated individual. The item that does not immediately appear to carry such content is "gets moody." However, this also requires an attribution by the mother of a specific mental state to the infant and such attributions, of "being moody" tend to be accompanied by related behaviors on the part of the mother, such as withdrawal. Hence, it can be argued that this item also captures a relational aspect of the mother's perceptions of her infant. Thus, we argue that the face validity of the instrument, as a means of capturing components of a mother's working model of the infant in relation to her, is amply demonstrated.

Independence of the Axes

The inter-correlation of the two axes was statistically significant but low in magnitude ($r = -.27$, $p < .01$), indicating only 7.5% shared variance. This shows that a perception of low infant warmth is weakly associated with a perception of high invasiveness. This level and direction of inter-axis correlation is comparable to that found for the widely-used Parental Bonding Instrument, a 25-item questionnaire assessing representations of parenting along axes of 'care' and 'control' (Parker et al., 1979), equivalent to the axes in the MORS-SF. Thus, the relative independence of these axes is supported.

Test-Retest Reliability

As noted earlier, an additional administration of the 44-item MORS was carried out for test-test reliability assessment with 36 mothers of infants aged between 6 and 12 months. For the MORS-SF Invasion scale, the test-retest reliability coefficient was $r = .77$, and for the Warmth scale it was $r = .70$.

Distribution Statistics for the Original Datasets

For the original British dataset, the MORS-SF Warmth axis mean score was 29.0 (SD = 3.7) and for Invasion, 11.3 (SD = 4.3). For the original Hungarian dataset, the Warmth score mean was 28.8 (SD = 3.3) and for Invasion, 7.8 (SD = 4.0).

Conclusions

The psychometric properties of the MORS-SF, as assessed from data in the original MORS 44-item Hungarian and British datasets and an additional Hungarian reliability dataset, have been shown to be adequate, and sufficient to warrant further validation of the instrument. As well as providing scores on the two primary axes, this version will also be sensitive to fine-grained differences, such as the cultural differences evidenced in these data. Clearly, further work would be valuable to confirm its utility for research purposes—for example, to examine the relation between MORS scores and narrative interview data using a protocol such as the Working Model of the Child Interview (WMCI; Benoit et al., 1997). Exploring links with mothers' personality dynamics would help to identify causes of variation in mothers' attributions arising from this source. It would be of interest to investigate links between variations in mothers' behavior towards their infants and MORS scores, and to use MORS to investigate possible transmitted effects of mothers' working models on infant development. It would also be of value to explore further the balance between projective and reality-based content of mothers' attributions as assessed on these axes—for example, by exploring the contribution of independent measures of infant physiological differences such as reactivity. The short-form, MORS-SF, has been shown in this study to be of potential use as an easy-to-administer research instrument to assess mothers' models of their infants on the two axes of perceived invasiveness-withdrawal, and warmth-coldness of the infant towards the mother.

With continued validation of the instrument, the findings of these studies offer strong support for the future use of the MORS-SF in primary care, as the screening tool is non-threatening and easy to administer and score. The MORS-SF indicates potential difficulties in mother-infant relationships during the first 12 months postpartum and could aid decision-making about the deployment of appropriate supportive or therapeutic interventions and tracking response to treatment.

Note: Copies of both the 44-item MORS (formatted as a landscape, double-sided, A4 proforma in English and Hungarian versions), as well as the

MORS-SF (formatted as an A5 self-completion booklet entitled 'My Baby' in English, and Hungarian, Polish, Hindi and Simplified Chinese versions) are available from the first author.

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Appendix 1. The initial 44-item MORS and the reduced 37-item version.

	My baby:		
1	stirs me up	23	gets sad
2	is happy	24	knows how to get her/his own way
3	annoys me	25	is affectionate towards me
4	*loves me**	26	gets moody
5	is demanding	27	makes me anxious
6	winds me up	28	is unpredictable
7	goes to sleep easily	29	smiles at me
8	*recognises me**	30	*rejects me**
9	gets angry with me	31	is perfect
10	reminds me of his/her father	32	is exhausting
11	cries for no obvious reason	33	is too dependent on me
12	is easily comforted	34	wants too much cuddling
13	likes me	35	likes my company
14	is strong willed	36	wants too much attention
15	irritates me	37	is stubborn
16	cares about my feelings	38	*disappoints me**
17	is naughty	39	is greedy
18	'talks' to me	40	*reminds me of my father**
19	*reminds me of my mother**	41	laughs
20	gets frustrated	42	*is inquisitive**
21	likes to please me	43	needs firm handling
22	dominates me	44	likes doing things with me

* seven non-discriminating items removed to leave the final 37-item MORS

Conscious Conception: Foundations of Emotional Development and Considerations for Professionals Working with Families

Ann C. Caird

Abstract: Conscious conception encompasses physical, emotional, spiritual, and practical considerations that prepare parents to welcome, nurture, and parent their baby, and that form foundations for bonding and secure attachment. Parents' thoughts and feelings before, at, and after conception and discovery of pregnancy influence the baby's developing core beliefs of self, relationships, and the world. Parents' abilities to differentiate their thoughts and feelings from those of the baby are critical to the baby's developing felt sense of emotional safety and optimal development of self. Differentiation of thoughts and feelings also provides a foundation for healing and repairing ruptures within the parent-baby relationship. Very early needs for belonging, love, and support can be met with optimal very early parenting. The discussion of conscious parenting highlights five specific considerations for the work of professionals working with families with babies and young children.

Keywords: pregnancy, parenting, pre- and perinatal psychology

Conscious conception is the foundation for conscious parenting and is defined by David Chamberlain as "very early parenting" (1997, p. 3). Conscious conception is very early, attuned, emotionally present, and aware parenting, where parents prepare emotionally, spiritually, physically and practically to welcome and parent their baby. This kind of early parenting supports the parents in meeting the baby's physical needs as well as emotional and spiritual needs to feel welcomed and loved.

Ann C. Caird, of Hampshire, United Kingdom, has 30 years' experience working with families, babies, and children in various roles including maternity nurse, doula, early childhood practitioner, and sleep specialist. Ann holds a BA with Distinction in Child and Youth Studies and two sleep certifications. Ann has also completed trainings with Parenting by Connection and Aware Parenting and is a prenatal and perinatal psychology educator trained by APPPAH and Myrna Martin. Ann currently supports families internationally as a baby and child sleep specialist, incorporating prenatal and perinatal psychology and education into her work to promote parents' understanding and awareness of the influence and importance of early experience.

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Conscious conception considers the spiritual and conscious nature of the incoming baby before conception.

Verny and Weintraub (2002) stress that conscious conception is the ideal for all parents and babies, because it ensures both that babies are planned and wanted, and that parents are emotionally and intellectually ready to meet the child's needs; these factors, in turn, support emotional health, optimal development, and life potential. McCarty and Glenn (2008) stress that human development occurs on a continuum starting with preconception; the most influential period of development occurs within the "primal period," from preconception through one year of age (p. 121). This period is critical to the formation of belief structures, implicit memories, and perceptions of life, described by McCarty and Glenn as the "core implicit patterns" that "profoundly shapes our being in life-enhancing or life-diminishing directions" (p. 130).

Conscious conception is important for babies because babies are conscious, spiritual in nature, and have awareness even before birth. McCarty (2012) explains that babies have a transcendental awareness at an implicit level, which is in existence before conception. Before conception, babies have a subconscious ability for taking a "witness perspective" and facilitating "mutual and intentional mind-to-mind communication" and perception of the emotions, feelings, and intentions of parents (p. 90). Therefore, if parents are consciously attuned and resonate with their incoming baby in thought, feeling, and intention, and ensure a healthy, nurturing womb environment, the baby's sense of welcome, emotional safety, trust, and optimal health and growth are supported. Melton (2015) describes the proactive concept of "nourishing the attachment womb" before conception with the woman being the womb: Within this nurturing environment, the baby grows, matures, and develops perceptions and impressions of self and life (p. 3).

Parents' Preparation

Parents need to be aware that their health and their baby's future womb environment will directly influence their baby's physical and emotional health and development. They also need to be mindful in the preparation and examination of their own physical and emotional health and readiness for conception and parenting. Consideration of lifestyle, habits, and nutrition for both parents will support the baby's growth, health, and development. Michel Odent (2006) stresses the need for intentional preparation of the intrauterine environment for the baby's optimal health and development. Intrauterine chemical pollution related to man-made fat-soluble chemicals is detrimental to gene expression, which can potentially hinder optimal growth, health, and development.

Chamberlain (1997) explains that habitual use of teratogens such as alcohol and tobacco may damage the father's sperm and increase risk of childhood cancers and sudden infant death. Further, Chamberlain explains that a mother's alcohol intake at conception may result in the baby developing facial abnormalities. Mothers can ensure a sufficient intake of omegas 3, 6 and 9 very early in pregnancy to support development of the baby's brain and nervous system, as well as the mother's own nervous system (Axness, 2012).

Reducing stress through conscious consideration of practical factors is important for parents who hold the intention of attuning to and meeting the baby's needs. Maternal stress can be toxic for babies at conception and for developing babies throughout pregnancy. Axness (2012) cites research that indicates that stress before conception can seriously increase the risk of premature birth and miscarriage. Axness also explains that the mother's stress during pregnancy can negatively influence the developing baby's stress responses, neuro-circuitry and brain development, as well as increasing risk of low birth weight, irritability, fussiness, and sensitive temperaments. In my experience of supporting parents with baby and child sleep, irritability, sensitivity, and fussiness often result in settling and sleep difficulties, such as inconsolable crying and underlying agitation that prevents the baby *letting go* into peaceful sleep, as well as agitated and disturbed sleep with frequent waking and crying. Sleep and settling difficulties often increase parental anxiety and stress, contributing to bonding difficulties.

Conscious parents are more likely to bring awareness to day-to-day financial and practical affairs, balancing work with home and relationships, and making emotional as well as physical space for the incoming baby to enter into their lives. Making practical preparations for parenting supports the ability to attune to the baby's emotional needs. As Gabor Maté (2000) explains, optimal emotional development requires non-stressed, emotionally-present caregivers: However, distracted, depressed, and overly-stressed parenting will impact negatively on the baby's emotional development.

Pam Leo (2005) explains that parents' styles of parenting are related to cultural practices as well as their personal experience of being parented. Some parents may have experienced harsh parenting and are aware that they don't want to repeat those practices with their own children. Leo (2005) explains that parents are more likely to parent their children best when they can, "forgive, heal and not pass on previous hurts" (p. 33). Parenting unconsciously is more likely to replicate the past hurts and experiences and most likely to trigger reactive and impulsive parenting based on the parent's past experiences (Siegel & Hartzell, 2004). Mindful awareness and reflection of past experiences and how they impact present feelings, actions, and behaviors, however, opens the

opportunity for choice. Maté (2011) stresses that parents become conscious when they come into the present; in present awareness, an individual has the opportunity to not be influenced by past experiences. Patrick Hauser (n.d.), in the video *Fathers* concurs, expressing the importance of the father's reflection and bringing awareness to how they want to parent and why. Hauser explains that there is a shift towards fathers having more time to be home and opportunities to be involved in family life: However, fathers are often overlooked in parenting preparation. It's important that fathers are empowered to consider balance in work/home life and both reflect with their partners and concur with parenting decisions. As Elmer Postle (Postle & Owl Productions, 2007) explains in *The healing of birth* video, fathers need to know that they really do have choices in how they want to parent.

Connection and Attachment

Melton (2015) stresses that the foundations of secure attachment are set before conception; this occurs through the attunement of parents to the incoming baby within "conscious two-way connection" (p. 3). McCarty and Glenn (2008) describe this connection as "mother-baby interconnectedness" (p. 131). Communication with the incoming baby may be achieved naturally for many mothers: Conscious connection and communication can be achieved through visualization, prayer, meditation, and invitation (Melton, 2015).

Research by Schroth (2010) on prenatal bonding and its outcomes, concludes that prenatal bonding helps babies feel heard and respected at a deep level. Outcomes for mother and baby include less pain and anxiety during birth and more intuitive communication between mother and baby. After birth, babies are emotionally more stable, socially more mature, and have a greater self-awareness and self-esteem. The connectedness between mother and baby results in fewer interventions at birth, and reduced rates of postpartum depression for mothers (Schroth, 2010).

Thoughts, Feelings and Differentiation

Maté (2000) stresses the need for parents to heal previous trauma so they are more able to create emotional safety for their child. Critically, he says, it's the feeling of absolute emotional safety that allows the baby to be their authentic self. Maté (2000) describes the environment of emotions, feelings, and thoughts surrounding the baby that are critical to feelings of emotional safety and optimal development as the "invisible environment" (p. 56). The emotional states of parents impact the feelings of emotional safety of the incoming baby. Therefore, differentiation allows

conscious parents to distinguish and separate their own emotions and issues from those of their incoming baby (Melton, 2015). The ability and awareness for differentiation is more likely to result in attuned, conscious, and emotionally-present parenting. This in turn is more likely to result in responsive parenting and secure attachment, described by Siegel and Hartzell (2004) as *high road* parenting rather than reactive, impulsive *low road* parenting.

The Influence of Thoughts and Feelings on Discovery of Pregnancy

McCarty and Glenn (2008) acknowledge that experiences from preconception throughout the primal period set the "core blueprint" of belief structures and perceptions that influence later life experiences and relationships (p. 130). The nature of parents' thoughts and feelings and their ability for conscious differentiation is critical before conception, because as McCarty (2012) acknowledges, the baby is aware and has the ability for mind-to-mind communication even before conception. Parents can set a foundation for secure attachment and their incoming baby's felt sense of safety when they communicate welcoming thoughts and feelings to their baby (Melton, 2015). Axness (2012) stresses that welcome and joy at discovery of the pregnancy supports the feelings of belonging for the baby and contributes to development of positive self-esteem. Sometimes, as Axness explains, parents are not aware they have conceived, and therefore, are unprepared for pregnancy. For some unprepared parents, thoughts, feelings, and attitudes at the point at which the pregnancy is discovered may not be welcoming and loving, and therefore, may have lasting negative effects on the baby. Specifically, when a mother holds feelings of anger, fear, or blame at the point of discovery, a "foundation of existential rejection and terror" can be set within the baby, which may have implications on development and life experiences (Axness, 2012, p. 94).

Axness (2012) describes joy and welcome at discovery as profoundly influential to the baby's felt sense of belonging. Grille (2005) concurs, stressing that the parents' feelings of joy and welcome are important elements that set foundations of the baby's emotional wellbeing, feelings of physical and emotional safety, and of belonging and feeling wanted (p. 285). Feelings of being wanted and accepted are more likely to support attunement between mother and baby. Therefore, the supportive feelings and emotions related to discovery of the baby are more likely to result in mother and baby *interconnectedness*, which McCarty and Glenn (2008) stress is of high priority during pregnancy and the primary period (p. 131). In turn, interconnectedness will more likely ensure the baby's innate needs for belonging, security, love, and nurturing are met, which supports optimal development (McCarty & Glenn, 2008).

The most wounding emotional experiences influencing the baby are feelings of rejection and being unwanted, and consequently, the baby may develop negative belief structures based on feeling worthless and unwanted (Grille, 2005). Research evidence concludes that being *born unwanted* negatively impacts psychosocial development, and is related to poor mental health (David, 2006). Specifically, in adult life, those born unwanted are more likely to require psychiatric treatment and experience unsatisfactory sexual relations, more unwanted pregnancies, and more anxiety/depressive disorders (David, 2006). Further, Appleton (2017) stresses that early experiences relating to parents' being welcoming will result in the baby developing a felt sense that will encourage the baby to "expand out," to meet the world with pleasure, and the expectation of welcome and needs being met (p. 100). Appleton (2017) goes on to explain that when the prenatal experience is less pleasant, babies are more likely to "contract away from the world" with an underlying sense of anxiety (p. 100). Schroth's conclusions concur with Appleton: When the mother can reflect the baby's feelings and perceptions, she builds "a safe container for the foetus to expand and express itself, so profound self-esteem can grow" (p. 5).

Conscious Repair

It can be empowering for parents to know that striving to be perfect in parenting isn't realistic, and that previous unhealthy or negative thoughts and feelings related to conception or discovery can be repaired. Melton (2015) explains that conscious repair is based on the differentiation of one's own emotions and feelings from those of the baby, and as such, within the parent-baby relationship, repair can heal ruptures within the early relationship.

Conscious and attuned repair is relevant at conception and at the discovery of pregnancy, because as Patrick Hauser (n.d.) explains in the video interview, *Fathers,* at discovery of a pregnancy, a parent's previous history of being parented may surge forward. Hauser explains that fathers in particular can find themselves feeling nervous, unprepared, or even fearful about the future.

As explained above, the point of discovery of the pregnancy is an important stage in consciousness for both parents and the baby, and some repair may be necessary if initial feelings and emotions have been rejecting of the baby in any way.

Repair can be simple for parents to implement if they have understanding of the conscious and aware nature of the baby, and ability to differentiate their feelings and emotions from those of the baby. It is important that repair occurs after reflection and when the parent is emotionally attuned to the incoming baby. Melton (2015) acknowledges

the repair process can be easy to practice along with differentiation of feelings, and can happen at any age, even preconception. Pam Leo (2005) suggests the "3 R's of reconnection": rewind, repair, and replay, as a parenting tool (p. 38), and I suggest these can be an effective foundation for very early repair. Leo (2005) describes rewinding as simply acknowledging that the parent's thoughts, feelings, or actions were hurtful for the baby. This then flows onto the repair—apology from the parent, where the parent acknowledges the thoughts, feelings and/or actions were about the parent's feelings not, about the baby (or child), hence the importance of differentiation. Finally, replay can follow, responding with love and responsiveness, and supporting reconnection.

Conscious Conception and Meeting Needs

Conscious conception, then, is about attunement and connection with the incoming baby, which ensures babies feel wanted, welcomed, and loved, and as such, is the foundation for secure attachment and optimal development. Attunement and connection in this way will ensure the baby's sense of physical and emotional safety and emotional wellbeing, because holistic needs will be met. Conscious conception will also ensure core emotional needs are met, as identified by Grille (2005), which support optimal emotional development and health.

Grille (2005) identifies five stages of emotional development he describes as "rites of passage" that babies and children will universally experience from before birth, through to seven years of age (p. 270). At each developmental stage, Grille describes the core emotional needs of the baby or child related to the readiness for learning "emotional competencies" (p. 285). As emotional needs are met, the child develops an innate sense of self-worth, self-esteem, and healthy relationships: These are based on their experience and learning of core competencies, their *rights* within healthy relationships, and as a valued, unique individual. Optimal emotional development and health occurs when core emotional needs are met, and the child develops positive beliefs about themselves and healthy relationships.

The practice of conscious conception may also ensure that the baby develops a felt sense of their rights, as emotional needs are met before conception and after. This will then support the development of early core beliefs that support optimal emotional development, secure attachment, and health.

Grille (2005) defines and describes these 5 developmental stages as follows:

The first right is the baby's *right to exist*. The right to exist encompasses the baby's need to feel wanted, welcomed, and nurtured. As described above, these needs are met when parents are consciously and emotionally present for their baby from preconception, or from the point

of discovery of the pregnancy. When parents practice conscious conception and very early conscious parenting, they are more likely to support the baby's right to exist, promoting a core sense of feeling wanted and welcome.

The second right is the *right to "need."* This right is related to the building of innate trust in others that they will respond to and meet the baby's needs. The baby then develops the early core belief that life is nourishing, "plentiful and abundant" (Grille, 2005, p. 313). At its core, very early conscious parenting is about attuning to the incoming baby's consciousness, emotional awareness, and needs: Therefore, very early needs are more likely to be met and trusting relationships established at a very early stage, promoting optimal bonding relationships.

The third and fourth rights of children are the *rights to receive support* and the *right of freedom*. The very early attunement of the mother to her baby can support mother-baby communication and interconnectedness, so the baby feels supported by the mother's awareness. As McCarty (2012) explains, the preconceived baby has the ability for intentional mind-to-mind communication with parents: Therefore, with optimal mother-baby interconnectedness and attunement, the incoming baby has the freedom to telepathically communicate to parents and express her own will. Specifically, conscious conception supports the parents' abilities to differentiate their own feelings and emotions from those of their baby, allowing the baby emotional freedom for optimal development unhindered by his parents' stress and difficult emotions. Schroth's (2010) research also concludes that babies feel respected and heard, and are more likely to "expand and express" when mothers are reflective of their feelings (p. 5). This concept is in alignment with Maté's (2000) view of the importance of secure attachment, and the baby and child's need to develop into their unique authentic self, which promotes optimal emotional and social development and health.

Finally, the fifth right is the child's *right to love,* meeting the needs to feel love and be loved, and developing the core belief in oneself as loveable, and to experience pleasure. Within the conscious conception paradigm, the baby is more likely to be conceived in love and will feel love and welcome throughout early life. The parents are more likely to have loving relationships with the baby and each other, which forms the foundation of secure attachment—the template for future healthy, loving relationships.

Considerations for Professionals Working with Families with Babies and Young Children

In discussion of the main elements and importance of conscious conception, there are five specific considerations related to the work of professionals supporting families with babies and young children. These

considerations address the consciousness and awareness of the professional, and the nature of approaches in support of parents, babies, and children. Considerations also address the professional's role in empowering parents and families through provision of appropriate and supportive information and strategies, signposting to appropriate therapists, as well as supporting very early parenting.

1. Professionals working with families with babies and young children may not be working from a "conscious" mind of differentiation.

There is a risk that some professionals working with families with babies and young children work from an *unconscious* rather than *conscious* awareness. As described above, adults' beliefs, behaviors, and responses are typically related to their own childhood experiences. It is the personal development of conscious awareness and understanding of how early experiences influence an individual's beliefs, behaviors, and responses that is more likely to result in differentiation of thoughts and feelings, and therefore objectivity. There is risk that some professionals will be working from their own personal belief systems, their personal blueprint, and/or from their experience of parenting their own children.

When working with babies, children, and their families, there is a requirement for professionals to work with objectivity and awareness. Specifically, professionals need to be aware of the nature of possible parental stress that may be influencing attachment, relationships, and the child's felt sense of connection and emotional safety. They also need to be aware of any early experiences that may be influencing, or have previously influenced, the family, baby, or child's emotional and physical health, behavior, and sleep.

2. Pressure to *fix* sleep and/or behavior problems.

In my experience, some parents are unaware of the need for conscious attunement to their baby or child around sleep, and will view behavior and sleep difficulties as a baby- or child-focused problem. Sleep consultants and professionals supporting families often feel pressure from parents to "fix" the sleep and/or behavior problem, which is in alignment with Harms' (2017) discussion on emotional first aid. Harms stresses that if the level of distress and anxiety of parents is high, there can be high expectation placed on the therapist to provide a baby- or child-based solution to resolve the problem quickly. Unfortunately, the pressure of anxious, unaware parents towards unaware and unconscious sleep consultants, results in some sleep consultants providing guarantees and claims that they can fix sleep problems in a set time period, usually in

about two weeks. Other professionals may feel pressured to suggest disconnecting approaches such as *time out*. The methods used to address behavior and sleep problems under these circumstances are more likely to be behavioral approaches aimed at fixing behaviors and training the baby or child, which may not be appropriate for the family. These approaches may trigger and reinforce a cycle of distressed, anxious parents seeking *quick fixes* from unaware and unconscious professionals. Consequently, in these cases, there may be higher risk of cycles of trauma and disconnection being reinforced.

3. The need to balance parent and baby needs.

In relation to the previous point, there is often pressure to fix a sleep and/or behavior problem in the belief that the baby or child alone owns the problem. In some cases, there may be specific adjustments that can be made, such as adjustment of routines so they are in alignment with circadian rhythms, adjustment of sleep environments, reduction of screen use, and increased connection time, which may improve sleep as well as behavior. However, there is a need for professionals to look deeper to explore and recognize possible social and emotional influences on sleep and behavior, which can support the parents' understanding of how previous experiences may be underlying sleep or behavior difficulties. The need may arise for professionals to refer the family to other appropriate therapists or professionals for further support in order to ensure all underlying influences on sleep and behavior have been fully addressed.

4. The need for repair.

In some cases, parents will have previously implemented behavioral approaches to address sleep and/or behavior problems that have enhanced the parent, baby, or child's felt sense of disconnection. It is my experience that some parents, particularly mothers, feel distress and guilt over having used behavioral techniques in their desperation to resolve behavioral or sleep difficulties. It is important for professionals working with families to offer parents appropriate support. Providing reassurance and information about rupture and repair can be deeply reassuring and empowering for parents and healing for the whole family. Recovery from previous use of detrimental and disconnecting approaches is possible through repair and taking a slow pace.

I have also often found that parents who parent to extremes of the attachment parenting paradigm often become distressed if their baby cries. These parents will often experience a sense of failure for not soothing their baby immediately when their baby cries, in combination

with an unhealthy exhaustion from striving to keep their baby happy. Guilt and distress can be eased with reassurance and provision of information about differentiation of feelings, i.e., the normality of ruptures and how repair can happen, and the baby's need for freedom of expression, and to be their authentic selves, as described by Maté (2000). In these cases, professionals also need to consider the possibility of the parent's early experiences influencing his or her parenting approach and refer to support as appropriate.

5. Supporting very early conscious parenting.

Aware and conscious professionals working with families with babies and young children have a wonderful opportunity to inform, support, and guide parents with very early consciousness and parenting, setting the foundations for optimal bonding and attachment, which results overall in easier, more settled babies and less anxiety for parents. Babies and young children are more settled if parents are attuned and consciously aware of the emotional needs of their baby from the very early stages of parenting.

I suggest these five specific considerations are applicable to all professionals working with families with babies and young children. Professionals need to be aware of how their own early and very early experiences may influence their beliefs and responses, and how these beliefs may influence their approach and support for families, babies and young children. Conscious awareness of self and the ability to differentiate feelings and emotions encourages objectivity, as well as openness to considering and understanding early experiences and present circumstances of the parents, babies, and children they support. Objectivity, exploration, and understanding are more likely to result in the provision of appropriate, empowering, and supportive care and approaches that address parent, baby, and child emotional needs. Specifically, when professionals work with conscious awareness, parents are more likely to feel empowered and supported in meeting their baby or child's needs for emotional safety, trust, feeling wanted and supported, experiencing freedom to express and be heard, and feeling loved. Meeting these needs holistically supports, promotes, and enhances optimal emotional development, secure attachment, and achievement of life potential.

Conclusion

Very early conscious parenting supports parents' emotional, spiritual, and practical preparation for welcoming their baby. Parent preparation in terms of conscious conception can reduce parent stress, and in turn, promote parent attunement and responsiveness to the incoming baby. Attunement and mother-baby interconnectedness as described by

McCarty and Glenn (2008), needs to be prioritized, because research shows that responsiveness to the incoming baby promotes growth, optimal development, bonding, and secure attachment.

Parents' feelings and emotions during preconception and at discovery of the pregnancy are influential to the incoming baby's development of core belief systems that will play out in their development and relationships. Therefore, the parents' understanding of the need to recognize their own discordant feelings and how they may impact the baby is important, because they can then differentiate their feelings from those of the baby, and repair can happen. This awareness and ability sets a firm foundation for babies to develop to their full potential, and ensures the baby's core beliefs are those of belonging, feeling wanted, welcomed, emotionally and physically safe, and loved.

There is a need for professionals working with families with babies and young children to work from a state of consciousness and objectiveness. Professionals need understanding and awareness of how their own early experiences may influence their approach and objectivity when working with families. They also need to understand and consider how early experiences influence the parents, babies, and children they support. Professionals working with families have a wonderful opportunity to support parents in providing information and supporting understanding of conscious conception. Optimal preparation, in terms of conscious conception, supports the incoming baby's developing belief systems of self, promotes mother-baby interconnectedness, and supports optimal emotional development and secure attachment.

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Vincent van Gogh: The Impact of Events in His Early Life on His Artwork

Ofra Lubetzky, PhD

Abstract: In Winnicott's view, a *good-enough-mother* is one who adapts herself to her baby's needs near the end of her pregnancy and following the baby's birth, and can identify with him in his initial stage of absolute dependence. If the mother had previously lost a baby and was unable to mourn the loss, then the baby born after the lost infant has to struggle more to become himself as his mother is focused on the lost baby and cannot see the new one in his own right. This article examines the link between the painter Vincent van Gogh's creative activity and the influence of his earliest relational experiences on his work and paintings.

Keywords: pre- and perinatal psychology, stillbirth, Vincent van Gogh

What needs to happen at the beginning of life in order for a person to be equipped with the conditions that will enhance the personal experience that underlies a life of ever-increasing significance? One of Winnicott's (1965) famous statements is, "There is no such thing as an infant…when one finds an infant one finds maternal care and without maternal care there would be no infant" (p. 39). The mother is the first facilitating environment—the person responsible for providing the holding and equipping, and enabling the feeling of self-realization.

Winnicott (1971) wrote that from the moment of birth until death, there is no person without this reality. He added, only if this is a

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containing and facilitating reality, will the conditions be created for the unfolding of personal experience, which is the basis of life that is not only about survival, but infinite, constantly-created meaning.

In Winnicott's (1975) view, a good-enough-mother is one who adapts herself to her baby's needs near the end of her pregnancy and, following the baby's birth, can identify with him in his initial stage of absolute dependence. He referred to the mother's position in the earliest phase as "primary maternal preoccupation" (pp. 300-303). This describes a mother with heightened sensitivity, who is capable of devoting herself for a limited period to safeguarding her baby's ability to continue living. He goes on to describe how the mother allows herself to be created by the baby, and the baby is able to experience the illusion of creation that later will serve as a source for the existence of a constantly-creative life.

The mother gradually reduces her level of adaptation in accord with the infant's needs. Only when the baby begins to experience the mother as a separate object and not as part of his fantasy, can she then expose him gradually to the environment and to a level of frustration that he is able to bear. The baby can already wait a few minutes for food, because he is aware of what is happening around him and is familiar with the noises that indicate the food will soon appear. The waiting leads to the beginning of an awareness that the mother exists as a separate object from him, which marks the beginning of separateness. The path is that of almost absolute dependence at the beginning, which changes gradually to relative dependence on the way to independence.

In normal development, the child gradually becomes autonomous and acquires the ability to accept responsibility for himself independent of environmental support. The process begins with maternal care, followed by parental care, and continues to the extended family, which together provide the individual with the opportunity to journey further afield outside the family, and from there to educational frameworks and participation in various social groups. This is a widening circle that extends into culture and/or belief.

Failure on the mother's part in the early stage of the child's life includes reactions on her part to impingement by her baby. These reactions interrupt the infant's "going on being," as well as producing a "threat of annihilation," a very real primitive anxiety that includes death (Winnicott, 1975, pp. 303-305). If the mother had previously lost a baby and was unable to mourn the loss, then the baby born after the lost infant has to struggle more to become himself as his mother is focused on the lost baby and cannot see the new one in his own right. In such cases, various artists have to invent themselves at a later stage in their work in order to overcome the loss of an adaptive and loving mother. Only when the baby undergoes a good enough early holding experience will the world be endowed with personal meaning, and only then will he live a creative life

(Winnicott, 1975). This article examines the link between the painter Vincent van Gogh's creative activity and the influence of his earliest relation experiences on his work and paintings.

Vincent van Gogh (1853-1890)

Who was Vincent? How did his early history influence his life and his art? Vincent signed his works and letters with his first name, Vincent, because he sought to put distance between himself and his family. "I myself am different in character from the other members of the family, and really I'm not a Van Gogh at all" (Walther & Metzger, 2006, p. 26). Vincent signed his paintings as he signed his letters to his brother, Theo– with his first name. For this reason, only the name Vincent will be used in this paper, rather than van Gogh or Vincent van Gogh.

A Chronology (Walther & Metzger, 2006, pp. 702-720)
1853: Vincent van Gogh was born following the birth of a stillborn son of the same name on the same day on the previous year. He was the first of six children. His family lived at Zundert near Breda in Holland. His father Theodorus (1822—1885) and his mother Anna Cornelia nee Carbentus (1819–1907) married in 1851. Vincent's father had ten siblings who lived in various parts of the Netherlands.
1857: Birth of Theo, Vincent's brother. The two brothers were extremely close throughout their lives.
1861—1868: Vincent attends boarding schools.
1869–1870: Vincent's uncle obtained a position for him with the art dealers Goupil & Cie in The Hague. After completing his training, he was transferred to the Goupil's London branch. This was a happy time for him. Vincent's own career as an art dealer soon started. He joined the branch of Goupil & Cie in Paris and Brussels at the age of sixteen.
1871–1875: The family moved to Hevoirt. Vincent was transferred to the London branch of Goupil & Cie. He fell in love with Eugenie, who was already engaged, and he was extremely depressed and disappointed. The uncle arranged a transfer to Paris, but Vincent neglected his work.
1876 -1879: Vincent became an assistant teacher and his pay came in the form of board and lodging only. He was found to be unsuitable for the job of lay preacher and went to Amsterdam to prepare for the entrance examination to the theology faculty. He found the studies difficult, while at the same time his interest in painting was growing.
1880—1885: Vincent decided to become an artist and devoted his time to drawing. Theo began sending Vincent a share of his monthly salary until the end of his life. Vincent went to Brussels and stayed there a year. He went to Etten to see Theo and draw landscapes, He fell in love with his

cousin Cornelia, but she rejected him. This event lead to a violent quarrel with his parents whom he came to visit at Christmas, and he left the parental home. Vincent met Clasina in Sien, an alcoholic prostitute who was pregnant; he lived with her for a while and she occasionally sat for him. He wanted to marry her, but the family and friends advised against it. He left Sien and remained lonely. His paintings show the local peasants hard at work. He stayed in Nuenen where his parents were living, and painted a lot. His father died of a stroke. Here Vincent painted the famous picture *The Potato Eaters*. At the end of 1885, he moved to Antwerp.

1886–1888: After rejecting the academic Ecole de Beaux-Art, Vincent moved to Paris and lived with Theo. He became a friend of the Parisian painters. His mother and sister moved from Nuenen to Breda; some of his paintings were sold to a junk dealer and others were burnt. He became friendly with Gauguin. He exhibited with some friends without success. Vincent then left Paris and moved to Arles where he painted *The Sunflowers.* He moved into the Yellow House in Arles. Gauguin came to Arles to be with Vincent. Their conflicting views led to quarrels and a deterioration in their relationship. Gauguin left the house in a hurry. Vincent then mutilated his left ear lobe and remained in a hospital recovering for a few days. This bitter quarrel with Gauguin was the first of Vincent's crises and hospitalizations. The two artists didn't meet again.

1889—1890: Vincent returned to the "Yellow House." Under pressure from the town people (they called him "The Redheaded Madman"), he was again hospitalized. Theo married Johanna Bonger. Vincent entered Saint-Paul Asylum. At the end of the year, he tried to poison himself by swallowing paint. An article was written praising his paintings for the first time. Theo's wife gave birth to a son christened Vincent Willem. His painting *The Red Vineyard* was purchased. This was the only painting Vincent ever sold. Vincent arrived in Paris looking fit and healthy. He had been working every day, interrupted only by his bouts of madness and now he paused for a while. He couldn't be inactive for long time. He traveled to Auvers-sur-Oise to Dr. Gachet. Vincent exhibited ten pictures. "Your paintings in the show are very successful," wrote his brother. Vincent was no longer a stranger to the art world. He was seen as one of the promising new talents.

July 27, 1890: Vincent fired a bullet into his chest and died, with Theo at his bedside. His last words were, "I wish it were all over now the sadness will last forever" (Walther & Metzger, 2006, p. 692). He was buried in Auvers-sur-Oise cemetery.

January 25, 1891: Theo died and was buried alongside Vincent at Auvers-sur-Oise. Theo's widow remained dedicated to watch that Vincent's art was seen by the public.

The Painter, Vincent

From the vast material that has accumulated on Vincent's life and work, there is very little evidence of his relationship with his mother. My intention is to focus on the connection between events prior to and following Vincent's birth, the relationship with his mother and his brother Theo, his functioning as an artist, and his tragic death.

Vincent wrote:

> Not only did I begin drawing relatively late in life, but it may also be that I shall not live for so very many to come ... I only take into account plans for periods of between five and ten years … and that is how I see myself–as a man who must produce something with a heart and love in it, within a few years I must produce it by will power … In a few years I must finish a certain body of work. (Walther & Metzger, 2006, pp. 95-97)

Vincent was an autodidact and completed the vast majority of his works over a ten-year period (Shoham, 2002). His paintings demonstrate his genius, creativity, imagination, and freedom of spirit, which were his legacy. His paintings were a vehicle for self-expression.

The Mother, Cornelia Anna Carbentus van Gogh (1819-1907)

The extensive literature on Vincent devotes very little attention to the mother's relationship to her first-born child and his stormy life. She lived a long life and died 17 years after Vincent's death. In all the difficult events of his life she was not present and did not give him support. It would seem she did not believe that his decision to become an artist was suitable for him. An incident that sheds light on her attitude to his works was that when she sold her home she burned some of his works and others she gave to a junk dealer.

Vincent, the mother's first live birth, as was mentioned above, was born following a stillborn son of the same name on the same day a year previously. In Winnicott's (1975) view, a baby born a year later to a mother who had previously lost a baby and was unable to mourn the loss, would have to struggle more to become himself because his mother was focused on the lost baby and could not see the newborn baby in its own right. In my view, Vincent tried to invent himself at a later stage with help of his art in order to overcome the lack of "holding" by a *good-enough mother*. What was missing could not be replaced, but remained a strong desire throughout his life and work. Vincent did, however, find a substitute for

his mother's care in his beloved brother Theo, who supported him unconditionally.

The Brother, Theo (1857 – 1891)

More than 800 letters were exchanged between Vincent and his brother, Theo, which provide an ongoing picture of Vincent's personality and his art. Four years younger than Vincent, Theo supported him emotionally and economically throughout Vincent's life until his death. It would seem that the close relationship with Theo was a substitute for the lack of closeness to his mother. Theo loved and appreciated Vincent, supported him financially, paid for his painting materials, and played the role of father, confessor, and sympathetic critic of his paintings until the end of Vincent's life.

Throughout his ten creative years, Vincent expressed the fear of being a heavy burden on his brother, even though he needed his support and was dependent on it. He expressed his difficulty of dependence in a large proportion of his letters. In one letter, he wrote, "...dear brother how strongly and intensely I feel the enormous debt I owe you for your faithful help" (Roskill, 2008, p. 187). He also wrote, "I have been afraid that I am causing you all anxiety because I am a burden on you, but ... plainly proves that you are aware that I, too, am distraught and as worried as yourself" (Walther & Metzger, 2006, p. 692, L 649).

After Theo got married, Vincent wrote:

> … you know now that I have started to hope once again. I am hoping that a family will be for you what nature is to me, the clods earth, the grass, the yellow wheat, the farmer–that is to say, that your love of human kind will not only bring you toil but also afford you comfort and necessary recovery. (Walther & Metzger, 2006, p. 607, L 604)

Theo had always been extremely close to his brother and was sensitive to his needs. In the following passage, after Vincent's death, Theo perceptively expresses what he considered to be Vincent's essence. He wrote, "I discovered a man of integrity as if two people dwelt within him. One of them marvelously talented, refined and tender, the other selfish and hard-hearted…" (Walther & Metzger, 2006, p. 692).

Vincent, the Person and the Painter

All of Vincent's various activities and occupations before he started to paint, whether as an art dealer or pastor to miners living in poverty, or living like the peasants themselves, did not bring him satisfaction.

Rather, they gave him the feeling of being in a false position. Having decided to become a painter, he initially drew laborers of all kinds: miners, peasants engaged in active pursuits, digging up potatoes, weavers at work, etc.

He was aware, however, of how his decision to paint affected his relationship with his family. He wrote, "I have become … a kind of impossible and suspect personage, at least somebody whom they do not trust … the most reasonable thing for me to do is to go away … so I cease to exist for you all" (Roskill, 2008, p. 102, L 117). He added, "I consider myself a dangerous man, incapable of anything" (Roskill, 2008, p.103), and, "…most people who know me consider me a failure … I feel it so vividly that it quite depresses me … life is only a kind of sowing time, and the harvest is not here" (Walther & Metzger. 2006, p. 92, L 184).

In his drawing he wished to create a world of his own and to grasp it in his work (Walther & Metzger, 2006). The following extracts from his letters to Theo reveal most profoundly Vincent's view of the significant role of art in his life. He wrote, "I am an artist … always seeking without absolutely finding…" (Roskill, 2008, p. 111, L 148). A few other examples are:

"I can very well do without God both in my life and in my painting, but I cannot … do without something which is greater than I, which is my life – the power to create" (Walther & Metzger, 2006, p. 286. L 673).

"Art demands persistent work, work in spite of everything, and continuous observation" (Roskill, 2008, p. 151-155).

"…the duty of a painter to try to put an idea into his work" (Roskill, 2008, p. 178, L 288).

"I cannot paint so beautifully but abandon myself to it so totally that I let myself go without paying attention to any rule" (Walther & Metzger, 2006, p. 398, L 539).

"When I receive the money my greatest appetite is not for food, though I have fasted, but the appetite for painting is stronger … at once I hunt for models, and continue until all the money is gone" (Roskill, 2008, p. 253).

"… I do have a right and reason to paint ... It has cost me no more than a ruined body and a wrecked brain to live as I was able, to live as I had to, as a friend to all humanity" (Walther & Metzger, 2006, p. 466, L 513).

"Work you have slaved over, work you have tried to put your character and feelings into, can give pleasure and sell" (Walther & Metzger, 2006, p. 92, L 185).

"The sun itself cannot make the world bright without souls to feel it" (Roskill, 2008, p. 266, L 595).

The cypresses were Vincent's torches of the soul and in them the painter was expressing what he had called "the essence of the landscape" (Roskill, 2008, p. 266, L 595). Because of his ultimate solitude he had to

go through all the possible concepts that linked him to nature – a process that left him with partial answers or none at all, and feeling more desolate than ever (Walther & Metzger, 2006). He wrote, "…know no other way than to wrestle so long with nature that she tells me her secret" (Roskill, 2008, pp. 224-225, L 480).

In his letters, Vincent expressed a desire to merge with nature, to feel the landscape and the connection to the sun, the sky, and the universe. In addition to his tremendous talent as an artist, it is possible to sense, on the basis of his lifestyle and of his paintings, Vincent's strong longing for containment and a sense of meaning that were lacking from the beginning of his life and maybe even before his birth.

Vincent struggled to maintain a sense of his own existence. Through his art he hoped to achieve a connection with nature and its mysteries, that nature would reveal its secrets to him, and enable him to find the thread that would bridge the primary feeling of existence that seemed to be so lacking in him, and his wonderful ability to create.

Did Vincent succeed to be the creator of a world—a world that already exists? He believed that the painter's task is to praise the world, and nature, and in so doing to infuse it with life and being (Wright, 2009; Winnicott, 1971). He was painting the world into existence, and in so doing, giving it a dimension of life it lacked for him before. This desire, however, could never be fully achieved, leaving him restless and dissatisfied. Indeed he was never happy with what he had achieved, criticized himself most severely, and provided an ongoing commentary on himself as a painter. "…I do not care anymore what people say about me or about my work" (Roskill, 2008, p. 253, L 550).

Vincent also drew many self- portraits that seem to be exterior mirrors of his emotional loneliness. Possibly these portraits gave him the possibility to "exist and feel real" (Winnicott, 1971, p. 134), because at the beginning of his life he was unable to find himself in the mirror of his mother's eyes. Vincent wrote "…I've always had the belief that through portraits one learns to reflect…a portrait is something almost useful and sometimes pleasant…" (Walther & Metzger, 2006, p. 332).

Towards the end, especially after Gauguin's visit, he felt a depth of despair that led him to severely injure himself, the start of his mental deterioration. In his last painting, *Wheatfield With Crows*, the crows prevent escape from the bitter fate—the inevitable ending (Shoham, 2002).

After Vincent's death, Dr. Gachet wrote, "He was an honest man and a great artist. For him, more than anything else there were only two things: humanity and art" (Walther & Metzger, 2006, p. 692).

Illness and Death

Gauguin's two-month sojourn in Arles was of central importance in Vincent's breakdown and death. For Gauguin, the concept of a unity of art and life, which for Vincent had been evolving perfectly naturally, had no validity. He behaved brusquely and arrogantly and with a feeling that Vincent had exiled him to a provincial, uninspiring region. For Vincent, the meeting with Gauguin was traumatic. Faced with the increasingly-apparent incompatibility of their approaches, Vincent became more and more unsure of the value of his own work and his identity. For Gauguin, the cost was far less significant; he would simply have to leave, writing off two wasted months. But for Vincent, it meant the destruction of a worldview. The utopia all his toil had meant to establish finally proved unattainable.

Gauguin left suddenly and set off for home. The two artists were never to meet again (Walther & Metzger, 2006). On the night before Christmas Eve, Vincent mutilated himself by cutting off his earlobe and giving the lobe to a prostitute. Vincent was hospitalized to stop the loss of blood caused by the wound. A month later, he had an attack of paranoia that led to repeated hospitalizations (Walther & Metzger, 2006).

During his last two months in Auvers-sur-Oise, Vincent was more cheerful and confident. During that time, he painted some eighty works. Again the artist demanded of himself all that could possibly be demanded of a human being. He was determined to create an enduring memorial before he vanished for all time from the face of the earth (Walther & Metzger, 2006).

Both Vincent's art and his life appear to have been guided by his strong fear of death. He wrote, "In the life of the painter, death may perhaps not be the most difficult thing… we take death to go to a star…while alive we cannot go to the star, any more than once dead we'd be able to take the train…" (Roskill, 2008, p. 272, L 641).

Hirschfeld (2018) wrote in reference to the painting *Skull of a Skeleton with Burning Cigarette*, that Vincent scratched death in his paitings. Like smoking, death is enjoyment; the death instinct is a pleasant and painful itch that needs to be scratched.

After the shock of mutilating his ear lobe, Vincent did not return to himself. In the periods of quiet when he was not hospitalized, he drew rapidly and with enthusiasm; during the periods of hospitalization, he experienced anxiety, despair, and loneliness.

The time between his mental breakdown and his suicide included periods during which his profound creativity was not affected. However, a combination of his inability to paint during the attacks, his wish not to place an additional burden on his brother for financial support, and his

fear that the buds of success that were beginning to sprout would exact a high price, all led to his suicide. After his death, Theo wrote to their mother, "He has found the peace he never found on earth… He was such brother to me" (Walther & Metzger, 2006, p. 694).

Discussion

Vincent the artist demonstrates the link between his early biography and his decision to be a painter. He was born after his brother's death. In his very early life, he was unable to find himself in his mother's eyes because she was probably mourning the lost baby and was occupied with the memory. As quoted above, "There is no such thing as an infant … when one finds an infant one finds maternal care and without maternal care there would be no infant," (Winnicott, 1965, p. 39). A good-enough mother is one who adapts herself to her baby's needs and can identify with him in his initial stage of absolute dependence. This is a mother who is capable of devoting herself for a limited period to safeguarding her baby's ability to continue living (Winnicott, 1971).

Failure on the mother's part in the early stage of the child's life includes reactions on her part to impingement by her baby. These reactions interrupt the infant's "going on being," as well as producing a "threat of annihilation," a very real primitive anxiety that includes death (Winnicott, 1971, p.132).

Because Vincent lacked the crucial initial "holding," he looked for a "hug" in nature, an external mirror that would see him and nourish him with the possibility to "exist and feel real" (Winnicott, 1971, p. 134), which was a never-ending task. The artist therefore tried to create a new possibility of being, one that his mother was unable to provide him in his early childhood. In this respect, Vincent's paintings can be interpreted as an expression of the unresolved traumas he underwent very early in his life.

In one of my earlier articles (Lubetzky, 2015), I discussed three great artists who underwent a similar chain of events in their early childhood, and how this affected their creative endeavors throughout their lives. The present article adds an additional layer of understanding in relation to Vincent's artistic work. This article focuses on the significant connection between the events that occurred in the early years of Vincent's life, before and after his birth, particularly the relationship with his mother (parents), his close connection to his brother as a mother substitute, his functioning as an artist, his powerful longing to connect with nature and its mysteries, and finally the tragic and painful end to his life.

My hope is that the above will add a layer of familiarity with the artist, his way of working, and the loaded and rich life of a great artist–Vincent van Gogh.

This article is dedicated to the memory of my unique painter sister, Tova Meller.

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In Memoriam
John Chitty RPP, RCST®

April 15, 1949 - February 28, 2019

The Association for Prenatal and Perinatal Psychology honors the passing of John Chitty, celebrated teacher of Polarity Therapy and Biodynamic craniosacral therapy, and an ardent supporter of babies. His blend of therapy combined ancient wisdom with current health practices, and he had a particular focus on the sacredness of early human development. He and his wife, Anna Chitty, started teaching polarity therapy in 1979 and opened the Colorado School of Energy Studies in Boulder, CO in 1992. At the end of his life, John created Polarity Counseling. He was a presenter at APPPAH conferences and a frequent lecturer in the Monday LIVE lecture series in the Prenatal and Perinatal Educator Certificate Program.

We are particularly grateful for John's contributions to understanding babies and the autonomic nervous system. In alignment with APPPAH's mission statement that babies are conscious beings, John took this one step further. He often said that babies are the royalty of humanity; they are super-sentient and deserve the best treatment. His protocols for working with babies started with the theme of recognition; to babies we say, "I know who you are (a unit of consciousness). I know where you come from (an invisible, spiritual, magical place). And I know why you are here (to have experiences on planet Earth to gain wisdom from experience."

Our efforts combined when educating students in our programs, especially in the domain of neuroscience and the polyvagal theory. John donated the 6th chapter of his book, *Dancing with Ying and Yang: Ancient Wisdom, Modern Psychotherapy and Randolph Stone's Polarity Therapy* (2013) to our education program. His lectures to our students emphasized understanding the baby's story, the use of energetic and nervous system state recognition, practitioner skills, and how special babies are. He was very generous in his teaching, offering many lessons through YouTube for free, podcasts of his exercises, and handouts of many kinds that can be found on his website: http://www.energyschool.com.

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John was unable to attend his last lecture for APPPAH at the regional conference in Denver, 2018 because of his illness with cancer. That lecture, Talking with Babies, was one of his favorite topics because he represented the intelligence and super-sensitivity of babies, and how our current birthing practices need to be upgraded to be more thoughtful and gentler. His book, *Working with Babies: A Five-Step Therapy Method for Infants and Their Families* (2016), outlines a protocol that includes talking with, and listening to, babies in utero as well as newborns. He pioneered the use of the two-chair approach when helping families to understand the baby's experience. This approach combines the wisdom of pendulation within a polarity of nervous system states with direct experience, so that families can really communicate with, and understand, the baby. His books and presentations have stories of improving difficulties prenatally, during birth, and after birth by simply "putting the baby in the chair," or having the adults in the baby's life engage in gentle inquiry from one chair, and then switching to become the baby in the other chair. Many families benefited from learning this form of gaining insight into the consciousness of their children, and themselves.

John's teaching and presence in our community will be forever remembered. His pioneering teachings, often done with great humor and grace, encouraged a greater understanding of humanity. APPPAH was very fortunate to have his support and contributions.

Kate White, MA, BCBMT,
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Book Review

Maternity Leave: A New Mother's Guide to the First Six Weeks Postpartum. Cheryl Zauderer. Amarillo, TX: Praeclarus Press, 2016. 210 pages. ISBN-13: 978-1939807434

The period immediately following the birth of a newborn can be a tumultuous time of uncertainty, exhaustion, and discomfort for a new mother and family. In *Maternity Leave: A New Mother's Guide to the First Six Weeks Postpartum,* author Cheryl Zauderer helps new mothers navigate challenging times throughout this transition and answers many of the questions new families are confronted with. Zauderer tackles several main topics, including post-baby body, breastfeeding, love and sex, bonding, and most significantly in my opinion, mood disorders. *Maternity Leave* speaks to the spectrum of readers post-birth; whether it's your first baby or fifth, whether you have an abundance or lack of financial resources, and whether you have a large or limited support system, this book is for you. Zauderer speaks to the challenges of postpartum without pathologizing the experience, but rather allows for a normalization of many fears new mothers face. Overall, I was impressed with the content of Zauderer's work. However, there were some sections that lacked clarity, organization, inclusivity, and a personal element, which failed to consistently maintain this reader's attention.

Although the physical postpartum period has existed since the beginning of time, the topic of postpartum physical, mental, and emotional health has only recently been openly discussed as something within a new mother's control. Of critical importance is the focus on mental and emotional components of the postpartum period, which are often neglected in a culture dominated by western medicine. Zauderer fills a much-needed gap in education for new mothers, not only with what do and expect as they heal physically, but how to heal emotionally and mentally post-birth. Zauderer doesn't necessarily tell women what to do; rather she empowers them to assess what they need and speak up for themselves, while validating the spectrum of varied experiences. A main message throughout the book is to take care of yourself, by enlisting the help of others, letting your body rest, and checking in with yourself, so that you can be the best mother you can be. Zauderer says this is important because

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"there has never been a time in your life when you have had so many changes to your body and your mind" (p. 11).

In my opinion, the greatest asset of *Maternity Leave* is its relatability. At the beginning of each chapter, Zauderer quotes specific thoughts and questions new mothers may have related to a certain topic. Zauderer also integrates paragraphs acknowledging the spectrum of varied experiences and individual differences in a series of statements starting with "you may." The author then takes the time to give specific answers to commonly asked questions. Zauderer's book offers a guide with step-by-step how-to's on topics including skin-to-skin contact, nutrition, baby wearing, Kegel exercises, pain relief, healing techniques, alleviating PMS symptoms, and splinting a cesarean incision. Zauderer also devotes an entire chapter to postpartum mood disorders, explaining each of the different depression and anxiety disorders' symptoms and prevalence. While there has been an increase in awareness of postpartum depression and the baby blues, largely due to celebrity influences, there is a lack of information on the spectrum of mental health concerns post-baby and a significant stigma of mental illness still persists for new mothers. This chapter's focus on mental health can help encourage women, partners, or loved ones to seek help when needed, reduce the fear of what could be wrong, and allow families to take steps to prevent, recognize, and intervene following signs of postpartum mood and anxiety disorders.

Although Zauderer covers an abundance of information in her short and easy-to-read book, there are some topics that could have been explored further, including newborn sleep behaviors and how to handle sleep. At one-point, Zauderer suggests not putting the newborn on a strict sleep schedule, and another time she states the baby should not be left to cry-it-out alone. However, she does not address what parents should do in regards to sleeping, how often they should sleep, and how to tolerate the stress of a newborn's sporadic sleep regimen. Zauderer also mentions how breastfeeding with your infant in bed can be a risk factor for sudden infant death syndrome (SIDS), but she does not discuss the other risk factors and recommended practices for safe sleep during infancy. This is particularly important, because SIDS is the leading cause of death for children under one year of age. I believe more information regarding this topic should have been included in a book focused on the first six weeks postpartum.

Overall, the layout of *Maternity Leave* is sensible and easy to follow. I found the most beneficial organizational components to be the thorough contraception chart and various lists of to-do's, symptoms, or recommendations. However, I thought some of these lists could have been more succinct and clear. For example, the diet and nutrition chapter could include a sample weekly or daily meal or snack suggestion, while the partner chapter could include more exact steps on topics such as burping

and skin-to-skin contact. Zauderer incorporates photos of each different breastfeeding position that I found to be immensely helpful. I believe additional images could be helpful to clarify information such as swaddling, diapering, and newborn bathing.

One section I had a particularly hard time getting through was post-baby body and post-baby cesarean. Even as someone with a background in medicine as a nursing student, these two chapters felt overloaded with medical information that I found to be both daunting and laborious to read through. Although I believe it is important for new families to be educated on health complications, I think these chapters could benefit from personal stories to break up the constant list of symptoms, and could be written using lighter, more colloquial terminology. Another issue I find is a brief mention of biofeedback, without any description of what it is and why is should be used.

At the end of each chapter, Zauderer includes a resource page that I find to be tremendously helpful as a place for families to locate additional information on certain topics that may pique their interest as they read. Additionally, the suggested reading at the end of the book is helpful for gathering more information. However, I think these resources could be better organized into an integrated section on resources (books, websites, etc.) by topic, rather than alphabetically by author, so that they are easy to find based on what the reader wants to know. Further, an index and/or glossary with relevant definitions and where you can find additional information on the topic in the book would be beneficial for quick and easy references to guide readers in real time.

Finally, I would be remiss not to mention Zauderer's impeccable credentials, which provide her with the necessary expertise in postpartum mental and physical health. Zauderer's background includes a PhD in Psychology, Certified Nurse Midwife, Psychiatric-Mental Health Nurse Practitioner, and Certified Lactation Consultant. In addition to these impressive degrees, she has an abundance of experience with postpartum women as a psychologist in private practice, as a registered nurse for 30 years, and as an assistant professor at Hofstra Northwell. The appropriate use of references throughout the book suggest the presence of significant academic influence on her work. Zauderer has written more than a dozen articles in professional journals on perinatal mental health. She is highly qualified to write about the first six weeks postpartum and is likely among the most informed and experienced writers on the topic.

Reviewed by Alexa Lantiere
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Book Review

When Postpartum Packs A Punch: Fighting Back and Finding Joy. Kristina Cowan. Amarillo, TX: Praeclarus Press, 2017. 280 pages. ISBN-13: 978-1946665003

When Postpartum Packs a Punch: Fighting Back and Finding Joy, by Kristina Cowan, showcases both personal experiences and evidence-based research on various mental health conditions surrounding postpartum mood disorders. This book serves as a guide for mothers, partners, and their families, as they experience the life-changing journey of childbirth and new parenthood. Mothers and their partners are provided with the necessary tools needed during the prenatal and postpartum period to identify symptoms and factors associated with traumatic childbirth experiences and/or postpartum depression. Cowan identifies and thoroughly explains the risk factors, prevalence, and symptoms associated with the most common illnesses arising from perinatal trauma; she incorporates the stories told by mothers and their partners and how they confronted this issue, as well as the current treatments being used to reduce the negative impact of traumatic births and postpartum depression and anxiety disorders.

Many mothers are unaware of the challenges that can take place during the prenatal and postpartum period, which may lead to improper treatment or lack of treatment altogether. Cowan addresses the five most common mental illnesses that women encounter around the sensitive time period of childbirth: prenatal/postpartum depression, prenatal/postpartum anxiety, prenatal/postpartum obsessive-compulsive disorder, postpartum post-traumatic stress disorder, and postpartum psychosis. She breaks down the framework into three parts: the illnesses, fighting back, and hope for the future.

First, Cowan speaks about the disorders, the evidence surrounding them, and the unknown facets about them. It was apparent, from Cowan's story and others, that there is a disconnect between many providers and mothers on the educational resources regarding postpartum depression and anxiety disorders. Many of the mothers felt as though these illnesses were overlooked, based on their past medical history and their support system, and wished they could have been more informed. Next, Cowan

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acknowledges how women and their partners have helped heal these disorders, and the resources they used to improve their health. Lastly, Cowan ends with society's approach to postpartum traumatic disorders, what's currently being done, and what else we're missing to reach a renaissance.

In each chapter of *When Postpartum Packs a Punch: Fighting Back and Finding Joy*, Cowan uses evidence-based knowledge and stories from various mothers to unpack the emotional turmoil, symptoms, and risk factors associated with postpartum depression and anxiety disorders. Starting with her own personal journey and then using the stories of different women for every other condition, Cowan reveals that each illness occurs at a different time for each person, and can be triggered from past or current family trauma, financial obligations, self-doubt, fear, and/or anxiety. Each experience described in the book shows that at some point of their postpartum journey, the mother and/or their partner felt alone, confused, fearful, or unsure of themselves in some way, and was worried for the safety of their child, their partner, or themselves. By the end of the book, Cowan offers the foundation of true support and open communication, real life stories of how and what symptoms to identify, and a list of perinatal psychiatric inpatient and outpatient programs available for any person enduring this type of suffering. Although everyone's story is different, it was clear to see that accepting the severity of their condition was the first step to ensuring a successful recovery. In each story, once the individual spoke up about their illness and began working towards improving their health, they grew less irritable and more comfortable in themselves. It helped them to identify their stressors and other factors contributing to the trauma or mental health condition.

Through real life stories and treatments, Cowan approaches the negative stigma of postpartum depression in the simplest manner possible. *When Postpartum Packs a Punch: Fighting Back and Finding Joy* is a resource that all mothers, their partners, and families can utilize during the prenatal or postpartum period. It provides an outlet for those individuals who might not have anyone to confide in, feel alone, or feel lost or out of place. By reading this book, I gained so much insight about how to care for myself, my family members, and my future patients, as well as how to identify any risk factors, symptoms, or severe behavior changes during the perinatal period. Cowan avoided any negative stigma of perinatal mental health issues and recreated an outlook that will improve the recovery from childbirth-related traumatic experiences and mental illnesses, no matter how severe the condition might be.

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Reader Comments

There were no reader comments on the Spring 2019 issue of the Journal of Prenatal and Perinatal Psychology and Health.