The “Original Couple”: Enabling Mothers and Infants to Think About What Destroys as Well as Engenders Love, When There Has Been Intimate Partner Violence

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Abstract

This paper addresses the importance for therapists, working with infants, of holding in mind all aspects of the parental couple’s relationship history, both positive and negative. This also includes the therapists’ possible ambivalence about a violent father. Using object relations and attachment theory frameworks we articulate our approach to the “original couple” when working in the area of family violence and infant mental health. We propose that if therapists can develop this capacity, it assists both mothers, and ultimately their infants, in tolerating thinking about their violent experiences. Work with infants and their mothers in an infant/mother psychotherapy group for those affected by family violence is described, illustrated by a clinical vignette.

Key words: “original couple”, fathers, infant mental health, family violence.

INTRODUCTION

When infants and their mothers have been affected by violence within the intimate partner relationship, how can therapists working with them usefully hold in mind the relationship of the “original couple”?

The term the “original couple” offers a construct with which to think about both the biological and the symbolic context of the relationship into which the infant was conceived. Whilst acknowledging the biological factor, it also allows consideration of the emotional, inter- and intrapsychic world of the infant, and enhances our capacities to think about the introjected parent-couple, as much more than a biological entity. This in turn fosters further thinking about the infant (and his or her experience) as more than a “product” of the coupling, and as a subject, in and of her own right. (In accordance with this, hereafter we refer to the infant as “she” and/or “her” rather than as the more impersonal he/she.)

Using object relations theory and attachment theory to frame our thinking about the “original couple”, we hope to offer an understanding of our
work that may prove useful to other therapists involved in the area of infant mental health, family violence, and work with couples. We will consider the interpersonal processes of intimate partner violence and the importance for therapists when working with infants to hold in mind both positive and negative aspects of the parental couple’s relationship history. This also includes the therapists’ possible denigration of, or ambivalence about, a father who is violent. The infants’ fathers are not usually participants in our therapeutic work. Reasons for this are multifarious; the couple’s separation results in a father abandoning contact/being in jail; court orders preventing contact; mothers/children residing in refuges, etc. Practitioners working in family violence services with women and children usually need their work to be undertaken separately from that with fathers and men. This is due to the risks to safety posed by the men’s past histories of extreme violence. While the rationale for this prioritises safety in reducing further violence, it may result in practitioners not being sufficiently supported to engage with the ideas this paper attempts to address.

The clinical example we have chosen to illustrate our thinking and approach as set out above, is drawn from our clinical experience of working, training and writing with colleagues of the RCH Infant Mental Health Program a time-limited specialist infant/mother therapeutic group work intervention at the Peek-A-Boo ClubTM (Bunston, 2006, 2008a), an initiative of Melbourne’s Royal Children’s Hospital Integrated Mental Health Program. The clients of the groups are infants from birth to thirty-six months, where the infant/s and mother have been exposed to family violence. The Peek-A-Boo ClubTM aims to create a space that is “infant led” (Bunston, 2008b) through privileging the experience of the infant. Clinical experience leads us to believe that either parent may be violent. While it is the mother–infant pair who are referred to the programme, which is elucidated later below, our therapeutic focus attempts always to hold the triad of mother, father, and infant, in mind. This paper addresses one dimension of that focus, the capacity of therapists working directly with both infant and mother, to be able to tolerate, reflect on, and process the intimate adult sexual relationships that have been, or continue to be, violent, occasionally even murderously so. While we recognise the importance of the exceptional complexities for children conceived as a result of rape or incest, (Paul, 2007), they are beyond the scope of this paper. Tangible legal and social responses are needed to keep mothers and infants safe from male violence. However, “we obfuscate the complexity of self and thereby of our relationships if we over identify with polarities that reduce rather than enlarge our understanding of the dynamics that play out in landscapes dominated by violence. This is turn limits our ability to effectively respond” (Bunston, 2008a, p.155). When therapists can develop this capacity, it assists the mother and infant’s potential
to think about, and make conscious, that which is often considered intolerable or is unconsciously split off. From this a different kind of thinking may enable some healing or resolution through tolerating the enormity and complexity of their violent experience. We see this capacity as part of the overall therapeutic endeavour which aims to attend to both the traumatic disruptions to the infant–mother attachment, resulting from exposure to severe familial violence, the “ghosts” in the mothers’ past (Fraiberg, Adelson, & Shapiro, 1975), and to the very present “ghost” of the absent partner/father.

The potential for dehumanising, dismissing, or denying of the other as a subject may occur when either parent resorts to destructive and violent splitting; such splitting has important and developmental impact on the infant and the family. Lieberman, Padrón, Van Horn, and Harris (2005), in their paper “Angels in the nursery” suggest the importance of holding in mind that which is good:

We propose that the parallel identification of “beneficial cues” can hasten recovery from trauma by placing the traumatic cues within the larger perspective of nurturing and growth-promoting experiences. (p. 507)

**AN ATTACHMENT APPROACH TO UNDERSTANDING VIOLENCE IN COUPLES**

Bowlby (1988) wrote, “violence . . . can be understood as the distorted and exaggerated version of behaviour that is potentially functional” (p. 81). In an effort to maintain or regain contact with another, anger, but not violence, can function as a form of protest. In healthy relationships it is normally responded to, by another, in an effort to hear and understand the protest with the aim of maintaining, restoring, or repairing the seeming breach/rupture in the attachment relationship at that moment. In intimate partner violence, when the frustration or perceived insensitivity of the other overwhelms the individual, anger may turn to aggression. As their best bid to keep their partner “available”, when they become overwhelmed by their internal well of despair and sense of powerlessness, the angry partner may resort to attempts to control the other, through abuse, intimidation, or coercion.

Early implicit memories of relational ruptures can activate primitive, inchoate emotional states. The subsequent aggression can be understood as a regressive and maladaptive effort to regain some sense of control. With limited creative or healthy ways to ensure proximity of loved ones, or to stave off the terror of being abandoned, one or both individuals may feel a desperate need to maintain contact with a partner whom they are fearful of losing. In the presence of such powerful feelings their approaches may
become coercive and emotionally destructive. Overwhelmed by primitive responses the distressed person cannot “think”, and instead “reacts” in response to the perceived threat. At such times, by grabbing at what they want, or pushing away what they hope to avoid, the other, as an individual demonstrating her own independence and separateness of mind, cannot be seen. Garcia-Moreno, Jansen, Ellsberg, Hesie, and Watts (2006) reporting in The Lancet on 24,000 women from fifteen different countries, found that men whose usual relational style is controlling are also more likely to be violent to their partners. The pursuit of control can be understood as an inflexible effort to manage anxiety that threatens to overwhelm.

Bowlby (1988) reminds us that the strength of an attachment is unrelated to the quality of that attachment. Bartholomew, Henderson, and Dutton (2001) confirmed this notion through attachment informed research with couples. They write,

we became impressed by how particular forms of insecurity appeared to put individuals at risk of becoming involved in, and having difficulty leaving, problematic and even abusive relationships. (p. 43)

The authors found that:

- dysfunctional relationships are often enduring ones, that is, abused individuals are likely to feel strongly attached to their abusive partners; just as children do towards their abusive parents
- paradoxically, even when the source of threat is the attachment figure, abused individuals seek proximity to the abusers
- abusive men/women tend to be insecure and overly dependent on their partners
- jealousy and fear of separation and abandonment are common triggers for abusive episodes
- leaving a relationship is difficult for individuals with a fearful or preoccupying style of attachment.

In some unhappy partnerships, individuals can face the hurts of separation, in the knowledge they will survive them. However, the authors found the most insecure individuals/couples are more likely to endure and maintain a relationship, even where abuse is a common dynamic.

Goldner, Penn, Sheinberg, and Walker (1990) explored love and violence in the couple relationship through the lens of a “gender paradox”. They proposed that men, and particularly those from rigidly prescriptive gendered backgrounds, learnt to be masculine by denying their feelings, primarily so as not to be like their mothers. Women, on the other hand, may need to refute their subjectivity and independence by becoming an “object” that a man would desire. Men and women often unconsciously
form attachments with one another in order to find that which they feel is missing within themselves. In their work with volatile couples who remain together, Goldner, Penn, Sheinberg, and Walker (1990) found that the “original” attraction for these couples “was [in] looking for a magical rescue from the loyalty binds and gender injunctions they experienced in their original families” (p. 360).

Evidence from couple and family violence research shows that men and women alike can be victims and can be violent. Acknowledging reciprocal couple violence or women’s violence is still controversial in the family violence arena and not often openly debated (Dutton, Saunders, Starzomski, & Bartholomew, 1994; Wangmann, 2011). Many practitioners have difficulty in being able to perceive women as using violence. It is recognised, however, that men perpetrate more severe physical violence and that women invariably are at greater risk of injury or death in violent heterosexual couple relationships (Salter, 2012; Strauss, Hamby, Boney-McCoy, & Sugarman, 1996).

When considering research findings about the enduring qualities of some abusive relationships, our clinical experience leads us to appreciate how little experience of healthy reciprocal relationships the men and women in abusive relationships have usually had. The capacity to build or create such a relationship requires, either an experience of a “good enough” emotional relationship, or, a well-developed ability to reflect upon and imagine what such a relationship might look and feel like. In the absence of these, a person’s internal world will, in many ways, be limited, leading to difficulties in regulating emotions, mentalising, reflecting upon, or finding words to deal with the pain of disruptions in their relationships.

We propose that violent behaviours reflect an individual’s own impoverished attachment relationships which are incorporated into an intrapsychic internal world in such a way that emotional distress is expressed as aggression, angry outbursts, or demands to be obeyed in efforts to control the other. These aggressive behaviours operate in response to their own urgent emotional needs. This understanding about early privations within the “original couple” is important. It extends the clinicians’ perspectives to encompass the minds of the mothers in our groups and their respective introjected parent couples. (While exploration of the mothers’ sense of their own original families is vital to our work, it is not a focus in this paper.)

Fonagy (2003), expanding on Bion’s pioneering work regarding infant containment (1962) and the capacity for thinking (1967), draws an association between the experience of feeling emotional containment and the ability to mentalise. Fonagy (2001) argues that clarity of self and other depends, from infancy, on being held in the mind of a care-giver who has a sense of self and other. He proposes it is the lack of emotional containment and being cared for by a parent/care-giver without the capacity to
mentalise, or think about the infant’s feelings and experiences, that leads to a disorganised state of mind, and further, fails in the normal developmental task of regulating “natural aggression”. Fonagy (2003) considers “aggression in infants” to be a normal phenomenon. An individual, with poor attachment experiences operating from a state of psychic disorganisation, has no possibility for finding a way to think through the turmoil of aggressive feelings and so fails to master them. An adult, who needed to eschew his emotional life as a child, will have a limited capacity to deal with and manage the boundary between self and other leading to dangerous expressions of an unthinking kind.

The emerging evidence of a strong link between the disorganised state of mind and violent behaviour is compelling. In a lecture entitled “The male perpetrator: the role of trauma and failures of mentalization in aggression against women”, Fonagy (1999) outlines his views regarding the transmission of trauma:

The child’s understanding of minds critically depends upon a developmental opportunity to find himself represented in the caregiver’s mind as a mentalizing individual (an intentional being motivated by mental states, beliefs, and desires). Their parents’ mentalizing capacity is . . . a good predictor. Thus a theory of mind is, first of all the other’s theory of mind, then a theory of self and finally a theory of the other. Mentalization, the capacity to understand and interpret human behaviour in terms of putative mental states underpinning it arises through the experience of having been understood in the context of an attachment relationship. This, in our view, is a critical aspect of the transgenerational transmission of abuse. (p. 3)

UNDERSTANDING VIOLENCE AND TRAUMA

The phenomenon of interpersonal violence in all its different manifestations is hard to gauge, define, and adequately measure. Recognition that violence within relationships can be due to the intra-psychic/interpersonal emotional disturbance within the couple is essential for therapeutic endeavours. Yet we wish to also acknowledge that social impoverishment (poor education, race discrimination, drug and alcohol abuse, and poor housing all contributing to unemployment and poverty) can lead to extreme stress and failure in the emotional holding a couple is required to bear. Salter (2012) reminds us of the lack of adequate “housing, employment, health and other difficulties that are prevalent in the lives of serious domestic violence offenders and victims” (p. 18). We hope that in a contemporary psychoanalytic paper, these vicissitudes that increase the distress on couples can be acknowledged, reflecting the thrust of our paper; the importance of holding in mind all aspects of the relationship history.
When there are children, the complex choices of leaving a violent partner (male or female) are multiplied. Severing school and community connections and embarking on a life of reduced income and single parenthood often result from these separations, particularly for women. Weighing up the consequences of leaving, the attendant shame and threat of chronic poverty, compared with staying in an abusive relationship, contribute to the turmoil of the decision making. Research indicates that women will leave a violent partner between four to six times over a period of eight years before doing so permanently (Gondolf, 1988; Horton, & Johnson, 1993; Okun, 1986; Walker, 1979).

The trauma of intimate partner violence may damage or even destroy an individual’s capacity to remember the nuance and complexity of the relationship. It is important to think about how therapists can become drawn into colluding with avoiding what has been lost or destroyed, thereby eschewing the often painful and complicated memories of early love and attachment that have been eclipsed by the violent events. Collusion by therapists may mean that opportunities to enable the mother–infant dyad to integrate some of the “good and bad” aspects of that infant’s parent’s relationship are also lost. Without some integration of their different parts, the infant’s future capacity to tolerate ambivalence in herself as well as others may be compromised.

The mother’s capacity to hold and contain her infant will be enhanced by her greater understanding of the complexity of the history of her relationship with the infant’s father. Our case vignette below demonstrates an infant’s responses to her mother’s emotional turmoil. Infants, who remain alone and uncontained in these situations, may be at risk of developing a defensive identification with the aggressor/perpetrator or identification with the powerless victim. Such “either/or” identification was first described by Anna Freud (1936/1966). Sigmund Freud (1923b) made the assertion that trauma that has not been resolved will repeat. Fraiberg, Adelson, and Shapiro (1975) and Fraiberg (1980) built on Freud’s idea when they brought this notion to the heart of infant parent work in the seminal paper, “Ghosts in the nursery”. Fraiberg, Adelson, and Shapiro (1975) describe work with infants and parents and propose that the “ghosts in the nursery”, metaphorically, represent the repetition of the past conflicts and traumas in the present.

Some women cannot recognise the extreme implications of the violence for themselves or for their children. Their denial can become converted into an impulse frequently to forgive or idealise their partners which risks minimising the abuse. This may partly explain why many women repeatedly return following a partner’s pleas for forgiveness and a commitment to change. This “idealisation” maybe an unconscious defence against the pain of being alone, the guilt of being the one who abandons the
family, and/or feeling worthy of the assaults. This thinking can be both erroneous and dangerous for the infant. The consequence for the therapist in this situation might also be to overemphasise all that is bad in the father for fear of encouraging the woman to return to their partner, enacting a countertransference response to the mother’s idealisation. We are concerned here with the development of the therapist’s capacity to hold in mind both sides of the “idealisation/denigration” split that arise in this work. It behoves therapists to take the preliminary step of tolerating and working through their own anxious defences.

By making space for reflection about the violence in what may previously have been an intimate relationship that contained some loving elements, mothers and their children are helped to create a more contingent authentic narrative surrounding the couple relationship. Such contingency fosters positive emotional development in healing the splits that resulted from trauma. With therapeutic support the mother may be able to provide a less fragmented narrative to her infant. When a child is given a more authentic account, over time, she has a better chance of understanding herself and the often conflicted nature of her feelings about herself and about those she loves. We acknowledge, however, that it is not necessarily love that draws some women to a violent partner; love may never have been truly experienced or expressed within the relationship.

CONSEQUENCES FOR INFANTS WITNESSING VIOLENCE

Underlying our work is the indisputable finding that exposure to intimate relational violence can adversely affect the infant’s developing mind (Schechter & Willheim, 2009), particularly in relation to the development of self, of object relations together with the understanding of others, and capacity for empathy. Development in infancy is critical, and more rapid than at any other period, laying down the template upon which the rest of relational life will be built. Intervening early is therefore urgent work (Thomson Salo, & Paul, 2007).

Perry, Pollard, Blakley, Baker, and Vigilante (1995), writing about childhood trauma, were among the first to integrate neurobiological principles to the understanding of the emotional states children use to “adapt” to violence. If a child remains in a persistent fearful state, she will be easily triggered into anxiety or feeling terrorised. Such emotional states can become persistent traits as the child is highly sensitised to hyper-arousal and may use dissociation in order to survive psychically being in the presence of an attachment figure who may be both loving and also abusive. Lieberman and Van Horn (2005) report that children exposed to violence suffer sleep disturbance, bouts of intense fear and uncontrolled crying, regression in developmental achievements, aggression, and
non-compliance. Jordan (2007) alerts us to the consequences for infants who witness domestic violence, which may include feeding/sleeping difficulties, non-organic failure to thrive, traumatic re-enactment in play, hyper-arousal, and other symptoms.

Baradon (2010) raises the intense complexities for infants when there is only a traumatizing father in their mother’s mind. She writes,

“The mother may show an unremitting need for her infant to identify with her psychic position, so that there is not possibility for the developing child to create a separate notion of father.” (p. 134)

The concept of maternal projections is fundamental in all relationships. A significant component of the mother’s projection onto the child may contain the unwanted parts of herself. This may be her disowned part of self, which unconsciously re-enacts a love which is felt to be destructive.

**THERAPEUTIC WORK WITH INFANTS**

In her paper “Relating to the infant as subject in the context of family violence” Thomson Salo (2007) proposes that, “thinking about the infant as subject is about thinking of the infant as a person. This means the infant is talked to rather than only being talked about” (p. 182).

For the infants in our groups it is incumbent on the therapist holding our knowledge of them, what terror they may have witnessed, instigated by those who have both loved and harmed them. Yet the therapist must also find ways to work directly with them in the therapeutic space. Slade (1994) outlines that clinicians’ work is towards helping young children, primarily through play, to create their own notions, separate from those held by their care-givers.

When therapists create a play space in which all things can be thought and talked about, in which the infants and mothers feel held by the therapists, and where all participants and their experience are honoured, there is an opportunity to take something enormous and terrifying from the outside world and make it into something smaller and perhaps a little less frightening within their internal world (Singer, 2002; Streeck-Fischer, & van der Kolk, 2000). As the renowned paediatrician and psychoanalyst Donald Winnicott (1971) suggested, “children play more easily when the other person is able and free to be playful” (p. 60) and that “playing is itself a therapy” (p. 67). We take very seriously the idea of “playing as a thing in itself” (p. 54). Slade (1994) describes that,

by putting experiences into play rather than into words the child is creating a structure. And by playing with the child we become part of the child’s discovery of what he or she means to say and means to feel.” (p. 91)
OUR THERAPEUTIC CONTEXT

The Peek-A-Boo Club™ aims to create opportunities for infants and toddlers attending the group to experience a sense of mastery over their environments, as well as a safe space in which we endeavour to give meaning to experiences that do not make sense. We know infants and young children may “manage” horrendous violence by dissociation, sublimation, and/or re-enactment. Every infant in a Peek-A-Boo Club™ group brings her own conflicts and distress about traumatic memories.

The therapeutic frame for the sessions is not dissimilar to adult or child psychotherapy in that time, place, and group therapists remain constant. We are mindful of what the group comes to mean or represents for the infants and talk about this with their mothers, who, of course, will also have her own relationships with the other babies and mothers in the group and with the group therapists. Playful rituals have been developed which include songs for greetings and separation, and a lullaby song for farewells, as befits a group for infants. The use of music offers the infants a means to help them organise their experience and over time, enables them to anticipate predictable reunions and separations. Alongside this therapists both observe and engage in the play of each infant–mother dyad. However, play for these infants can be frightening and confusing. In all our work, we are acutely interested in how these traumatic events are expressed, what aspects are emphasised, what are omitted, and what level of affect is conveyed. Infants can sense that there are secrets that are not to be spoken about, as if something is so terrible that even their parents, who should protect them, dare not speak about them.

CASE EXAMPLE

Amelia was the only child of Julie and John, who married readily when they became aware of Julie’s pregnancy with Amelia. John, who was in his early thirties and ten years older than Julie, had lost contact with his first wife and his first child, a son. Late in the pregnancy, John became concerned that Julie would leave him. As he became increasingly anxious, he started controlling Julie’s access to money and eventually he also became violent.

After an assault on Julie, where six-month-old Amelia was present, Julie left the home, taking Amelia. She returned to John a few times although the violence continued. Neighbours called the police and eventually Julie sought legal help. John was subjected to an intervention order preventing him from seeing his wife and child. John had agreed to get some psychological help for his “anger problem”, and made known his wish to return to live with Julie and Amelia. At two years and ten months old, the very active Amelia arrived in a Peek-A-Boo Club™ group. In the first meeting of the
group, as we got to know one another, the mothers settled as the toddlers explored the room and the toys that were scattered around the floor. Amelia enthralled the other three toddlers in the group, often leading them in vigorous games of “chasey”.

We felt Amelia appeared a little too assertive for a first group session. She began a game that consisted of her running furiously around the room yelling out, “SHUT UP! SHUT UP!” Then she whispered “Shhh, Shhh”, then half-hid under a cushion, holding her finger to her mouth to indicate to all to be quiet. She would then peek over the top of the cushion pointing to the window as though to indicate someone was coming and that we needed to keep out of sight. She did this repeatedly, and all in the room went quiet. The therapists wondered aloud what was being enacted by Amelia in this play. Eventually her mother whispered, “She does this game at home, all the time”. This seemed to open up the thinking space in which as a group we could wonder together what Amelia might be showing and telling us.

In an attempt to put the play into words, one of the therapeutic staff gently asked, “Amelia, why do we need to be quiet?” Amelia again “shushed” us, then rushed off. We asked Julie what she thought might be happening for Amelia. She explained that she felt it was something to do with her father, although they had never hidden from him. Julie explained that sometimes Amelia’s father would drive by them in the street or drive past the house, although he did not approach them directly. She told us the next time he breached the intervention order he could go to jail. Julie said she felt puzzled by Amelia’s game. When Amelia asked about her father, Julie would simply tell Amelia that Daddy was “on holiday” and that they could not see him at the moment.

The therapists suggested the play may be an expression of Amelia’s fear and confusion related to her traumatic experiences. They also wondered if it reflected Amelia’s wish to see her Daddy, as he was clearly in her mind. We wondered how often Amelia might have heard “Shhh, Shhh” or “Shut Up”. We also wondered how Amelia made sense of her father “being on holiday” with him driving by them in the street.

The question, in our minds, and taken up in supervision, was how can we help Amelia and Julie, and naturally the other mothers, think about their infants in their particular family and what each had experienced. Amelia was told Daddy was on holiday, yet her mother talked about jail in Amelia’s presence in the group. Amelia seemed to us to have enacted something of her anxieties and longing for her Daddy, yet also possible fears of what might happen if he did come home. We explored the confusion in her play, and related it to our thinking about Amelia’s memories and/or fantasies of Daddy, and maybe fears that Mummy was not strong enough to protect her. Her mother was helped to notice how watchful
Amelia was towards her, and consider both the need for and the impact of this vigilance. We used the play to allow thinking about Amelia’s unspoken worries about her father as a fearful presence, alongside feelings about him not being at home.

In one session, we worked more closely with this mother–infant pair (in the presence of all the group mother–infant dyads) to help Julie create a more honest account about the violence and the current parental separation. Julie eventually asked how she might talk to her daughter more truthfully. We have found this a common question once the therapeutic work is underway. She was able eventually to explain to Amelia that Daddy got very, very angry and hurt and frightened them both, and that that was not OK. She also told her Daddy was getting some help to be less angry because he wanted to see her as well. In our work with Amelia and Julie, we noticed that, as these conversations evolved, so too did Amelia’s “game”. We observed that Amelia transformed the “Shhh Shhh” into a more inclusive “chasey” game that could be enjoyed with others, taking turns excitedly to chase and be chased.

Over the next few sessions, Amelia continued to play the same game while other children and the facilitators “joined” her in the game. Slowly the game took on a different dimension and her disquiet seemed to turn to something more playful and less traumatic. By the conclusion of the group Amelia’s coercive-fearful play diminished and other more spontaneous and negotiated play took its place.

**THE INFANT (AMELIA)**

Amelia’s capacity to enact something of her aggression and the fear she had witnessed was thought to be both a sign of her distress and a strength. It demonstrated her emotional capacity to bring symbolic meaning to her play. This is “playing as a thing in itself” (Winnicott, 1971). It is also play where she becomes the aggressor—one who can command others with her own, “Shut up, shut up”. Fear is aroused in others as she requires all present to submit. The mothers responded with silence. Amelia was not left alone with her traumatic play, as one therapist actively joined with Amelia while the remainder of the group spoke about its meaning.

We considered that this may have evoked similar traumatic memories for other children and their mothers, and thus we wondered about this play and its meaning for the group as a whole. Observing and actively engaging Amelia, her mother and all members of the group in reflecting on the meaning of the play, helped to contain it and brought about a reduction in Amelia’s anxiety. This talking is delicately balanced between adults talking and direct work with the children. We attempt to attend to both the child and the dyadic work in our two hour sessions.
THE MOTHER (JULIE)

We should also consider what Julie, the mother, might have been projecting into Amelia. The mother deceived, but also confused Amelia about her father’s whereabouts and the violence. This may be the mother’s best attempt to “save” the relationship and protect Amelia from the brutal reality. Yet Amelia’s coercive play shows us otherwise. In avoiding an honest reply to her daughter’s entreaties about her father, her mother created a quandary for her daughter. By denying Amelia the truth, she risked losing opportunities for helping Amelia to process both her fears and losses. Amelia both wanted her Daddy and feared his return (the unknown intruder). Was this Julie’s wish projected into Amelia? Where is her anger and shame at being violated, when she returned to John after the violence? We suggest the violence and its meaning, and the attendant terror was split off in the mother’s mind. The deceit about his whereabouts offered little protection for infant or mother, as is evidenced by the traumatic repetition in Amelia’s play. There is always a tension for the therapists between working with the mothers’ difficulties while attending to our infant patients. This reflects the mother’s dilemma; whose needs do they attend to first, their own or those of their infants?

THE THERAPISTS

The group process aimed to contain Julie and her own trauma sufficiently for Julie to both see and listen to her daughter’s fear of her father (the intruder) and a fear of being abandoned to deal with it alone. The therapists attempt to hold and support the group to think more together about their past. This often means that we explore how the other mothers first met their children’s fathers, what their hopes and dreams had been then, and what they had done with these early memories of less traumatic times. We create a focus on how and what the mothers thought and felt about their experiences of their own families, their loving memories and sadness about their own parents, as well as about their (ex)partners.

A vital aspect of our therapeutic work is support for the therapists to ensure they are available to infant, mother, and the group as a system. This includes weekly supervision with a psychotherapist, and additional training, aimed at optimising the containment of all the members of the group. This is a challenge, as the very nature of the material participants are encouraged to think and talk about evokes and resonates with the most fearful, vulnerable, and violent aspects of themselves. We acknowledge the power of countertransference responses for the clinicians, how this is worked with in supervision is beyond the scope of this paper. Many of the therapists involved in this work are supported by their own psychotherapy.
Supervision attends to the impulse to “not think” about violence and the ensuing violation of infant’s minds. Traumatised people can underestimate the risk to themselves or to their children; therapists need to be vigilant they do not unwittingly collude by ignoring, or neglecting, danger signs. Their own therapeutic model must equip them with the skills needed to be alert to those signs and to take appropriate action with child protection services and/or the police, if necessary.

THE “ORIGINAL COUPLE”

The notion of the “original couple” enables therapists to think about the infant’s experience more richly. It includes the infant’s own internalised self derived from her own early object relations. Every infant will have their own experience, memories, feelings, and fantasises about their father and their mother and also her introjections regarding the violence witnessed and/or experienced themselves. If her father has left or abandoned them, or been removed from living in the home, there may be conflicted feelings of perhaps dissociation, numbness, or relief, mixed with guilt, sadness, and loss at being separated from her father. It is our role as therapists to help infants and mothers to try to separate what belongs to each of them and to recognise their experiences as being different. Clinicians need to be able to think about the intense feelings left in the abused mother/father, with the possibility that such feelings may also be projected onto the child. We also need to consider a child’s play as being both an enactment with the group of the traumatic experience and as possessing unconscious elements. Our clinical vignette clearly demonstrates the therapeutic power of being able to process together highly evocative experiences. We believe it is important to raise with the mothers in the group, early memories and experiences of love, even though that love has often been destroyed. We aim to reach the shame inherent in the mother’s unconscious compulsion to seek a love object that both attracts and ultimately repels her, someone who is excitingly familiar and yet ultimately dangerous and possibly even deadly. Some mothers may have heightened degrees of ambivalence about the pregnancy and/or infant, as the new life raises anxieties about being excluded and about their capacities to love another. It may be that both partners perceive the baby as an object who will come between them; neither parent may have wanted a baby. There is always a risk that the baby may be destroyed if they do stay together. There is unfortunately not space to expand on the partners’ sometimes sadomasochistic dynamic, where they both feel unlovable but cannot tolerate such feelings.
DISCUSSION

Themes of trauma, violence, loss, and distress are ever present in work with infants who have experienced violence within their parent’s relationship. In the group we create a space to allow the meaning of these relationships and the events that brought the women/infants to us to emerge. This attends also to a need for “counterbalance”. Some experiences, some of which may have been shared with the father, may have been loving and beneficial. It is incumbent therefore on infant–parent clinicians to think about love, when violence has felt to be so destructive. Lieberman, Padrón, Van Horn, and Harris (2005), as quoted above, suggest that therapists need to seek out, that which was once beneficial and may still promote growth, in relation to the infant’s father.

Thus thinking about what destroys, as well as what engenders, love occurs in the presence of the infants. As all the infants assessed and accepted into this therapeutic programme have been exposed to significant, if not lifelong, violence, might not speaking about it in their presence add to their trauma? What the infants have taught us is that they bring their experiences and fantasies into the therapeutic space, via their play. We believe these children live, see, feel, and introject these experiences, whether the mothers are talking about the violence or not. We also believe the baby cannot wait for the mother’s recovery. This is urgent work with rapidly developing minds. The group experience enables each mother’s capacities to hold her infant in mind, supporting her to create a congruent and meaningful account in a way that is particular to her and her child. Being heard and held by the group, mothers often also see their infant anew, recognising her as a sentient human being with a mind and a memory.

CONCLUSION

The enactment of destructive phantasies in intimate adult relationships, often itself arising from the experience of early childhood trauma, poses serious threats of injury and death. Our therapeutic endeavour is essentially family-based, yet the actual separation of the parental couple in our work is imperative when family members face death should the couple remain together. We are not absolving mothers from perpetrating violence, as this presents its own complex dilemmas in the mother–infant relationship and must be thought about. However this paper attests to the profound psychic presence of the absent violent father; absent from the therapy room as his behaviour is deemed too “unsafe” to be included, and absent from the relationship because the mother has fled or been abandoned.

Despite his physical absence, the father is usually highly present in the mind of the mother even as she denies his existence to herself and her
infant. It is valuable for infants’ mental health to keep open a space in our own thinking about the “original couple”. In infant work involving intimate partner violence there may be a pull towards thinking exclusively about repairing the infant’s relationship with her mother and to expelling any thinking about the parental couple. However, we risk losing something of great significance when we restrict our work to the infant’s relationship with her mother. The infant has a mother and a father, the sexual couple who created her; that coupling underpins her history. Therapeutic services that offer interventions for “violent men” for good reasons often operate separately from interventions for “survivors of violence” (mostly women). However, in this paper, we are proposing that therapists working with infants have a unique opportunity to be able to bring together the “original couple” in their own thinking, in order to enhance “integration” over “dis-integration” for vulnerable infants and their parents.

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NOTES

1. The names and some details have been changed to ensure confidentiality. Informed consent to present material from our groups for teaching purposes is obtained from all participants before any material is shared with others.

2. The work of the Peek a Boo Club™ was generously supported by the Sidney Myer Fund and The Grosvenor Foundation through the Victorian Women’s Trust.

REFERENCES


