Perinatal Depression in Four Women Reared by Borderline Mothers

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Full Text: Headnote ABSTRACT: As we become more familiar with the continuum of disturbances that are understood as Borderline Personality Disorder, we have come to know more about how the illness affects-and is affected by-other family members. Much less clear is our understanding of what can be expected in the life course of a person reared by a borderline parent. This paper offers a glimpse of that world, by way of reporting on the extreme anxiety and depression experienced by four women-each of whom appears to have been the child of a borderline mother-upon the birth of their babies. Characteristics of the families of origin, the story of each patient's struggle to announce her pain and to seek help (usually surreptitiously, by way of proclaiming worries about the baby), problems in treatment, and risks to the infants will be described. Especially noted will be the ways in which the vicissitudes of life in a borderline family may create not only an unusually attuned mother but also one unable to give credibility to her vague sense that something was terribly wrong in her family of origin-and that it is about to repeat itself in her care of the new baby. The role of the baby as a transference object for self will be seen as critical not only to the assessment of the peculiar qualities of these perinatal depressions, but as a useful element in treatment. The DSM III criteria for Borderline Personality Disorder are specific, and include eight characteristics: impulsivity; unstable, intense interpersonal relationships; identity disturbance; affective instability; intolerance of being alone; commission of physically self-damaging acts; chronic feelings of emptiness and boredom; and inappropriate, intense and poorly controlled anger. Clearly, not all patients who qualify for the diagnosis exhibit all eight characteristics, and there is a marked lack of clarity in the literature regarding the exact parameters of the diagnosis. Practicing clinicians often acknowledge a kind of borderline continuum, along which patients fall by virtue of their present functioning, capacity to engage in treatment, and the presence or absence of related or secondary disturbances. (Other diagnostic considerations often include major depressive disorders, and histrionic, narcissistic, paranoid and dependent personality disorders.) Clinicians in the field may first recognize such patients on the basis of the intense countertransferential reactions they evoke in the therapist-". . . using suicide threats, unreasonable demands, and a wide variety of other coercive behaviors to draw the therapist out of a position of psychotherapeutic neutrality and into the roles of caretaker, parent, persecutor, and adversary." (Waldinger et al., 1987, p. 6). While there seems to be consensus about the critical developmental period involved in the formation of the disorder-the "rapprochement" subphase (Mahler et al., 1975, pp. 76-108) during which the infant struggles simultaneously for separateness and for assurance of the availability, at any moment needed, of reunion with the primary caregiver-there is not universal agreement about how the disorder then forms. Masterson sees that the borderline's primary caregiver was not able to tolerate such movement toward separation and, therefore, gave messages to the child that emotional supplies would be withdrawn if the efforts at separation continued (Masterson et al., 1975). The interpersonal problems the patient experiences, then-as well as the transferences in treatment-reflect real experience (in infancy). Others suggest that the disorder-and the related transferences in therapy-may reflect gross distortions of childhood experiences by primitive defenses (Kernberg, 1975; Gunderson, 1984) or other deficits: in ego structure, as a result of utter failures in early gratification (Giovacchini, 1979); and in holding-soothing objects, resulting in extreme vulnerability to terror and panic, with no ability to evoke soothing images (Buie et al., 1982). Chessick's stunning conclusion regarding what the therapist says in the face of the powerful transferences during treatment of the borderline, captures rather well the therapeutic difficulties: "The patient is not interested in the words at all, any more than when the mother

picks up the baby, the baby cares which lullaby the mother is singing." (1977, p. 179). Indeed, while there is agreement about the centrality of transference in both the patient's acting-out and his acting-in, the rest of the consensus about treatment is limited to acknowledging that it is extremely demanding, fraught with pitfalls, and not necessarily likely to result in the patient's dramatic improvement. While practitioners have hypothesized about just how a borderline mother might care for an infant-and what the results of that care might be in the life course of a child-we have had few opportunities to report on how children of borderlines eventually seek help, or on how they deal with the birth and rearing of their own children. Masterson reports unequivocally that ". . . the mother of every borderline is herself a borderline" (1972, p. 22). But we have not been certain to what extent the opposite is true, nor precisely how "borderline parenting" affects the struggles of children to grow up, and even to become parents themselves. This author-a clinician in a specialized psychological practice treating disorders of attachment in parenting-has seen four women who appear to have been reared by a borderline parent, and for each of whom the birth of their own baby precipitated a major depression. While these depressions sometimes manifested in familiar themes-leading families and friends to accuse mother of "just feeling sorry for herself" or to smile knowingly about "baby blues," and the attending physician or consulting psychiatrist to diagnose short-term postpartum depression-it may be that these illnesses were unique: A. In two of the mothers, depression-mixed with extreme anxiety-surfaced during the pregnancy, at the time of the first sonogram, as the baby (or babies: one of the sonograms revealed twins) was first experienced as real, as a partial "Other" (Trout, 1986). Their experience contrasted, then, with the view that ". . . pregnancy appears to protect against major depressive illness . . . rather than provoking them" (Pauleikhoff, 1987, p. 44). B. There was a recurring tendency in each to apologize for having ever complained, to suddenly "get well," to promise never to have-or, at least, to talk about-"such silly problems" again, and to declare themselves unworthy of the attentions of the therapist. C. The distortions of parental self-image and extreme worry and guilt about causing the baby harm that are often seen in mothers with postpartum depression took a more profound form: projection of self onto the baby. Irrational assertions were repeatedly made about the suffering of these babies, who were actually becoming the transferential "mouthpieces" for these mothers. Mothers who were, then, unable to acknowledge the pain of their own early lives were "telling their tales" by speaking of the babies' imagined present and future life dilemmas and hurts. In one instance, mother even provoked the baby to scream endlessly, then interpreted the baby's upset in terms utterly inappropriate for the baby, but which profoundly revealed information about her own life at the time she was the age of her baby. D. The stories each told-on those rare occasions when each momentarily deemed herself worthy of speaking of her feelings, and in vague terms so elusive that even the patient could scarcely hold onto the memory-portrayed her mother as tortuously there-and-not-there; as loving, with enormous conditions (notably: that the patient behave well and make mother feel good by being pretty or smart); and as capable of horribly frightening acts of withdrawal. E. Even the feelings of imminent death so common during a major postpartum illness took an unusual twist: these mothers spoke less about wanting to die than about a fear-that each acknowledged as vaguely familiar, as if experienced long ago, before defenses began to protect-of simply ceasing to exist, of turning into nothing. F. Only one of the four sought help for herself. The other three brought their babies-including two who brought their fetuses-to the attention of their physician, saying that the baby was in trouble, or that the baby needed to have his/her feelings understood or to be protected in some way. CHARACTERISTICS OF THE SAMPLE Table 1 offers an overview of the four mothers in this sample. Depression, mixed with profound anxiety, was experienced by all four patients. In two cases this began immediately after the birth of the baby and led to almost complete immobilization, with the mother reporting that she was unable to think, unable to plan meals, unable to keep track of the time of day, unable to drive or concentrate or tend to her baby's needs. Both of these mothers were hospitalized shortly after the birth of the baby, one in a general ward for slightly over a week, and another in a psychiatric unit of a general hospital for nearly five weeks. In both cases these hospitalizations, and the psychotropic medications that were prescribed concurrently, interfered with

breastfeeding and, thereby, dramatically exacerbated already-present feelings on the part of the mother that she was failing her baby. In one of the cases, in which the child is now three years old, the mother still speaks with great upset about her too-early weaning of her baby, the extreme damage she believes this did to her baby, and her anger at the physician who prescribed the medication for her.

Table 1
Characteristics of the Sample

Patient	Parity	Sex of Target Child	Patient Age When Target Child Born	Onset of Symptoms	Duration of Major Symptoms	Duration/Frequency of Treatment
A.	3[1,2]	F	26	during pregnancy-after sonogram	four months before delivery to child's age two years (unresolved)	12 months/1X week
B.	2[1]	M	33	immediate postpartum	from child's age one week to two years	30 months/1X week (first year: 2X week) 5-weeks in hospital
C.	1	F	30	during pregnancy-after sonogram	four months before delivery to child's age one year	18 months/1X week
D.	1	F	32	immediate postpartum	from child's age one week to two years	17 months/1X week (ongoing) (first six months: 2X week) 1-week in hospital

[1]Mother reported having felt ". . . just the same way" at the time of the earlier child's birth, but the problem was misdiagnosed and, therefore, untreated. Earlier child was a female.
[2]Target child is a twin; mother reported problem only with the target (female) child.

In the other two mothers, the depression began during pregnancy, in both cases at the time of quickening. One of the mothers became extremely upset in her physician's office when, after a sonogram, it was revealed that she was going to have twins. She stated her disbelief, then her refusal to go through with the pregnancy, and then her intention to kill herself and the baby rather than let this event come to pass. The other mother whose depression began in pregnancy also experienced her first symptoms upon feeling the baby's movements and experiencing the reality of the life within her by seeing the baby on a sonogram at her doctor's office. She began to speak with great fear about the outcome of her pregnancy, particularly worrying that her baby would be ill, malformed, or otherwise damaged. Neither of the mothers whose depression began during the pregnancy (A and C in Table I) experienced the deep despair described by the two mothers whose depression began in the immediate postpartum period. Neither was placed on medication, neither was hospitalized, and one of the two defended against the depression by simply proclaiming it over, adding that she did not know why she became so upset upon discovering that she was having twins. Both had serious difficulty with attachment, repeatedly experienced extreme anxiety about the babies' well-being, and repeatedly engaged in re-enactments of old themes of loss, feelings of aloneness, and of being caught between conflicting needs-with baby playing the part mother once played, and mother both setting up the situations and trying to make them "come out better this time." In all four cases, the depression was severe enough to cause marital stress; disruptions in sleeping and eating patterns (along a continuum from mild to severe); problems in processing information; difficulty in planning and/or executing routine daily tasks; distortions of reality (regarding the motives of others, the meaning of their infants' behavior, their capacity to inflict permanent damage on the infant); and crying, irritability and

self-deprecation. Two (Mothers B and D on Table I) were so depressed as to be unable to carry out maternal caregiving tasks, and would have seriously neglected their infants had they not arranged for alternate care. Another's neglect (Mother A) arose out of her projection of self onto the baby, resulting in alternating feelings of empathy for, and then loathing of, the female of her newborn twins. FAMILIES OF ORIGIN A few characteristics of these four depressions that appear to distinguish them from the more common pattern of postpartum depression have already been noted. However, the central issue in grouping these four mothers is the striking similarities in the content of stories about their families of origin, their feeling states during the telling of such stories, and the nature of their defensive maneuvers following any mention of their families. While the hypothesis could not be confirmed in any case-and is, therefore, of questionable scientific validity-each of the four mothers appears to have been reared by a parent with borderline or narcissistic personality disorder. Stories about family of origin revealed that all four grandmothers experienced chronic feelings of emptiness and boredom (which each appears to have used her daughter to moderate); an intolerance of being alone (resulting in each daughter remembering her mother to be extremely attentive, almost clinging, and angry when the daughter tried to be either physically or emotionally separate); affective instability (including periods of sorrow and crying, for which the daughter always felt responsible, and periods of elation, which each daughter remembers desperately trying to extend); identity disturbances (noticed as an absence of self: "Sometimes it seemed as if she were living through me, that without me she wouldn't be anybody."); unstable, intense interpersonal relationships ("Crossing my Mom was a really dumb thing to do, and we all knew it-her friends, Dad, me. It wasn't so much that she would get mad; her ways of punishing someone who disappointed her were much harder to see than that-but you sure felt it."); and inappropriate, intense, and poorly controlled anger ("She could stay mad for days, or even weeks. Sometimes it seemed as if everyone she knew had wronged her, and she never forgot."). Impulsivity was observed principally in interpersonal terms; only one of the grandmothers seemed dangerously out of control of her impulses, and those were of the physically aggressive type. As far as the informantmothers knew, none of their mothers had ever engaged in physically self-damaging acts, although it is worthy of note that three of the four mentioned more than once her worry that her own actions could have lead to a suicide attempt on her mother's part. The grandiosity sometimes seen in narcissistic personality disorder was not described, although there was little question in any of the four mothers that her mother was the central figure of attention in her family of origin. Other narcissistic features were noted more sharply: lack of empathy (paradoxical, as utter insensitivity to-or empathy regarding-the child's needs, seemed to co-exist with extraordinary levels of attunement); extreme sensitivity to criticism; interpersonal aloofness (transient); entitlement; intolerance of the wishes of others; and egocentricity. A differential diagnosis could not be made, of course, as the therapeutic relationship with each of the patients precluded interviewing their mothers. Unquestionably, it is poor science to carry the diagnostic formulations too far, in the absence of access to the "patient" and relying only on the report of an intensely involved "child." It could not be ignored, however, that these four patients had in common not only a peculiar and long-lasting depression related to the birth of their children, and strikingly similar tales about their families of origin, but also a marked inability to say anything about those families of origin that might sound ungrateful. Each struggled valiantly to explain how very much her parents had always loved her, how nearly perfect her upbringing was, how utterly devoid her childhood was of"... that terrible stuff other people go through-you know, beatings, drunkenness, and a feeling your parents don't care-stuff like that." Nonetheless, each would also sob uncontrollably at times about something that was missing, something that was terribly wrong-then brusquely dry up, straighten her posture, and declare that she was just being silly, was acting like a spoiled child, was feeling sorry for herself, and had no right to "say anything bad about people who loved me as much as they did." Occasionally, there would be bursts of unexplained anger mixed with these episodes of unexplained sorrow, and what followed was predictable: self-rebuke, and a proclamation that it was ridiculous to get angry when there was nothing to be angry about. It was this painful struggle to get the story out, to find a way to understand a past that was simultaneously described

as idyllic and terrifying, that particularly set these four apart from others with postpartum depression. And it was this struggle that led the therapist to wonder-particularly in the absence of any report about alcohol use in the family of origin-about the possibility that one of the parents in each family of origin had been borderline or narcissistic. Commenting on this struggle, one of the four said (well into her therapy, and just before some of her more rigid defenses began to collapse): "I don't think I can stand this. If what we're starting to uncover is true, then I have to face that my mother didn't love me well enough. If it's not true, then I have no explanation for my feelings, and I'll have to face that I'm just crazy. Either way, I lose." The fathers of all four patients were generally described as compassionate, but also as weak and without the ability to protect themselves or their daughters from the narcissistic rage, the martyrdom, and the emotional abuse of the mothers. Each of the patients spoke of a vague yearning for this man in their life who never seemed quite available. One father (Mother A's) left the family in the patient's infancy, but was in and out of the house until she was six years of age, at which point he remarried and moved to a distant state. All four fathers were steadily employed, and one was a professional person. One of the four was described as difficult to please, emotionally unavailable, and tortuous in his convoluted demands on his daughter, just as his wife was. The other three were seen as distinctly different from their wives-as calm, loving, but so weak as to be "never quite there." Even ambivalence about families of origin was denied by these patients, at the beginning of assessment. Each was notably restricted and anxious in her description of her mother, in particular, and attempted to keep her remarks positive and generic. "Oh she loved me very much. I had a terrific home. You couldn't have asked for a mother more invested in me or more focused on everything I did." As more complete stories began to unfold, so did patients' efforts to backpedal, to explain, to reverse, and to apologize for complaining. The affect accompanying family stories was unpredictable, but could include fears, anger, extreme anxiety (sometimes marked by pacing about the therapy room), or a sudden flattening of affect, often followed by, "What is the matter with me? You must think I'm ridiculous for complaining about such things! I don't know who I am that I think I can gripe about somebody as wonderful as her; I'm not going to, anymore." When stories could actually be finished, the extreme subtlety of the tortuously there-and-not-there way each experienced her mother became clearer-but the patient virtually never caught the meaning of her own stories until they had been told over and over: 1. "My mother always liked me to look pretty, and so she would take extra time to pick out my clothing, brush my hair, and fix me up. She did this because she loved me. Sometimes I wished I could pick out my own clothes, especially when I got older. But I knew this would displease her, so I didn't. My mother loved me so much I thought I owed it to her to make myself look the way she wanted me to look." 2. "I remember I used to look forward to the mother-daughter dinners at our church with mixed feelings. It seemed that my mother was almost always angry at me, but she would change into somebody else on the night of one of those dinners. She might have been refusing to speak to me for the previous week, but I would always know that on that Wednesday she would be nicer to me. She would seem very upset before the dinner, so her arranging my hair and her choice of my clothes would be done with a lot of irritation. I would usually just be very quiet and do what I knew she wanted me to do, and not say anything as we got into the car. She would continue to not speak to me in the car, except to tell me things I had to watch out for at the dinner: things like not embarrassing her, being nice to certain people, things like that. Then, as we walked through the church door, a different face would come over her. All of a sudden she would start chattering to me, smiling broadly, and introducing me to her friends with great pleasure and happiness. Everyone would compliment my appearance and tell my mother what a terrific mother she must be to have a daughter like me. She just glowed. So for those few hours on Wednesday night once a month I was sure that my mother loved me, and sometimes that would give me the certainty I needed for the next several days. Sometimes I would remind myself later, when she wasn't speaking to me again, that she really did love me because she seemed so proud of me at those dinners. It did confuse me a little bit that, as soon as we left the church, she would berate me for all the various ways that I failed her that evening, and would return to not speaking to me. I always sort of wondered what that meant." 3. "I remember very well the

few times in my growing-up years when I talked back to my mother. We would be in the kitchen together, and she would be cooking or something and I'd be playing on the floor. I would be shocked when words came out of my mouth to the effect that I wasn't going to do something she told me to do, or that I had a different opinion than her on some subject. I would usually know immediately that I had said the wrong thing, and I would be terrified. I would usually jump up and start to run over to her to apologize, but by then she had already whirled around and had begun to give me that stare that she has. I knew that I had done something unforgivable, and that I was going to lose my mother again, at least for a few days. "After she stared at me for several seconds, she would always run off to her bedroom sobbing. She would slam the door to her bedroom, throw herself on her bed, and sob for what seemed like hours. (I guess it was probably only just minutes). I would lean against the door to her bedroom, too scared to cry myself, and beg her to stop crying and to come out. I would promise her all sorts of things: that I would be good, that I would never talk back to her again-anything to get her to stop crying, to come out, and to not turn away from me the next several days (as I knew was inevitable). Eventually, I would hear Mama get up from the bed, come over to the door and open it. I would then look up into a face that was glaring down at me, and I just learned to adjust to the fact that for the next several days there would be nothing I could do to get through to my mother, to make her smile at me again, to make her touch me or have anything to do with me. That seemed a reasonable punishment at the time, as I knew that I'd been very bad." 4. "You know, sometimes when I find myself feeling a little bit annoyed by my mother, I have to think of the fact that every day of the world until I left home, she polished my shoes for me. Polished my shoes for me-every single day! Isn't that something? How could you ever gripe about a mother who would do that for you? Every once in a while a terrible thought creeps into my mind that my mother wasn't polishing my shoes for me, but was polishing my shoes for her. Occasionally I even get the crazy idea that her polishing of my shoes was something she was doing to me, that it only increased my feelings that I was inept, that I couldn't get along without her. But then I realize that's silly, and I just tell myself again that my mother would never do anything to me that was not good for me." Clearly, these "failures to please" went far beyond the bounds of normal social development of young children in the context of their parental relationships. In every case the stakes were extremely high for the child failing to be the person mother wanted or needed her to be. In the most subtle ways imaginable, each of these patients gathered the impression that she could be-if she failed to put aside her true self in order to become what mother wanted her to be-abandoned. Many of them spoke of being in a kind of blackness, of feeling as if they were going to die, of being washed over by a sense that they were turning into nothing or that they were ceasing to exist. These were not fears of actual physical death, but seemed to be related to terrifying visions of simply being no more. Yet each patient's memory of these feelings-or her capacity to re-experience them-was sometimes elusive and fleeting, as if they could not be sustained without support. One said, "I wish I had been abused. Then my feelings would seem more real." One of the patients told the story that she viewed as silly, on the face of it, but which caused her to sob uncontrollably-sobs that were, I think, related to the fact that her story was a metaphor for her fears of abandonment. In the story, she is with her father (a perfect substitute, since her fears of abandonment were not related to him) in a book department of a large department store. She suddenly realized that he was no longer with her, and she began to look around for him. In the story, she proclaimed, she was a very mature and level-headed little girl who did not panic readily. However, as she continued to be unable to find him, she began to get afraid. She tried to stop somebody walking along to ask the person where her father was, but the person rebuffed her and failed to help her (just as most of the fathers in these families were seen as unwilling or unable to help). Finally, she asked a clerk to help her (just as most of these patients had described a fantasy of finding someone who would tell their mothers to be nicer to themand two of the patients actually did have figures like that in their early lives) and the clerk quickly found her father. She said that she then laughed at her own silliness, and promised her dad that she would be good and not get lost from him again. At no time during the story did she give any responsibility for the separation to her father, but simply assumed that she had been bad by failing to stay in touch with him. LIFE IN

THE CURRENT FAMILY All four patients in this sample were married during the period of treatment. Three were clearly the power figures in their current families, and saw their husbands as weak and ineffectual. Two of the four husbands were almost completely absent from the family. Mother A (whose father left when she was an infant) demanded that her husband become a long-distance truck driver as a condition of reunion, following a marital break-up during the pregnancy. (Something similar happened at the time of her first-born's birth: She did not want to marry the child's father, but-not wanting her to be without a fathershe married another man just after her daughter was born. Before the child was one year of age, however, she asked him to leave.) The husband of Mother D lived in a distant state, where he moved to find employment. (The patient declined to go with him.) The husband of Mother B-the only one of the four described as forceful and competent-lived at home, but was so involved in his business that he was rarely home before late evening. The husband of Mother C, the most available of the four, absented himself often by going on hunting trips. He regularly asked her to accompany him, but she declined. Each of the patients regularly complained about her husband's unavailability; only later in treatment did each begin to wonder about the part she played in orchestrating the separations. Except during the peak months of depression, all four mothers were competent and loving in their caregiving of their infants (and of the older child, in the cases of Mothers A and B). Each demonstrated-although not reliably-extreme attunement and sensitivity to change in her interactions with her baby. At times, each was extraordinarily aware of her baby's needs and feelings. Projection loomed as a constant danger in all four cases, however, as mothers spoke of infant hopes, motives, feelings and intentions and needs that were not their babies' at all, but their own. Sometimes the line between self and other was crossed without harm to the child, as when Mother D used great care in her selection of substitute care because, "Sometimes little kids feel scared and alone, and they don't know why." Mother A (who lost her father in her own infancy, only to have him return and leave again, on an unpredictable basis, until she was six) demanded that her husband become a long-distance truck driver just before the birth of her twins, but declared positively that her newborn desperately missed her father, and that this explained her persistent screaming. She did not want her husband to come home to stay, but it did seem important that someone acknowledge the "cause" of the baby's upset-which always stopped, mother explained, as soon as daddy walked in the door every four weeks or so. The male twin, presumably, did not miss his father as much, and did not scream. A videotape was finally made-at the infant's fifth month of age-recording the infant's calmness in dad's presence, her immediate and persistent screaming the moment dad "hit the road again," the instantaneous cessation of crying a few moments later when a truck-type air horn was heard ("Maybe she thought her daddy was coming home") and resumption of crying when mother went to the window and declared that the sound came from another vehicle. Later in that session, mother told the story-for the first time-of her father's departure in her own infancy, his unpredictable returns, and her mother's lack of support for any feelings of sorrow. Evidence that the baby was released from the transference-upon mother telling her story-was suggested by the fact that the baby's screaming stopped, she fell asleep, and the episodes never resumed. Day-to-day care of these four babies, then, was a mixture of extraordinary compassion and attunement, a range of projective identifications, sometimes very serious neglect (particularly during periods of the most powerful depression), intermittent decathexis, and rapid mood changes (usually brought on by a new round of depression, guilt, or interaction with mother's mother). Paradoxically, each patient actively involved her mother with the care of the baby. This was, without exception, upsetting to the patient and created, in some instances, an arena for uncharacteristically direct and angry interaction between the patient and her own mother over how to care for this baby. It appeared to be the case that the patient was "giving her mother a chance to do it right this time." However, when the patient's mother did, in fact, care for the patient's baby better than she had cared for the patient as a child (which was often the case), this became a source of enormous upset to the patient. It also was a great therapeutic aid, of course, as it made clearer, by contrast, just what the deficiencies had been in the patient's relationship with her mother as a child. Unfortunately, it also made several of the patients feel as if their mothers' bad treatment of them as babies really had been the patients' own fault-just as

each had originally suspected-since it was now obvious that the patient's mother was actually capable of providing much better care for babies than she had many years ago to the patient herself. It seemed apparent, in all four cases, that the patient was struggling to work out something with her mother by way of allowing her mother to take care of her baby. The almost daily upset this caused one patient made it seem likely that she was going to change her mind and have the baby cared for by someone else. However, she would keep going back, again and again, leaving her baby with her own mother, becoming upset at her mother for some part of that care (while not necessarily saying so to her mother), then "saving" her baby from her mother at the end of the day or the end of the trip, and starting it all over again the next day or the next opportunity. Only as healing began did each patient begin to find other caregivers for her baby, or begin to set clear limits and rules for her own mother with regard to the care of her baby. In a couple of instances the patient even began to use her baby as a wedge, making continuing contact between her mother and her baby contingent on her mother following some new rules: to be nicer to the patient, for example, or to demonstrate more respect for the patient's own mothering, or to stop giving the patient lectures about how to be a proper mother, or to stop engaging in her pouting or her other manipulative/martyr schemes. This was always most upsetting to the patient's mother, but seemed to be quite a source of delight to the patient, who found herself for the first time having power over her own mother. HISTORY OF TREATMENT Each of the four patients had received some sort of treatment prior to the birth of her baby. However, none felt there had been success, as the issues could not be defined in the presence of only denied or alternatively explained symptoms, and without a baby through whom she could speak about her own early life. Mother A had seen a counselor in high school related to her great sadness over the divorce of her parents, evoked anew by the subsequent death of a grandmother. Unfortunately, that counselor died, thereby adding considerably to the patient's struggles with losing objects, and adding to her fantasies that she was "too powerful for most people." Coincidentally, she also sought assistance from this author approximately three years before the birth of the twins. At that time she was a single parent of a three-year-old daughter, whom she brought for treatment. She refused to agree to see the therapist herself regarding her daughter's troubles, which she described as resulting from their living with the patient's mother, and ". . . grandma drives my little daughter crazy." In addition, she said that her daughter had no father, and ". . . she needs a man to talk to." Mother B-who came to my attention due to extreme depression (requiring hospitalization) following the birth of her second child-reported that she had also been extremely depressed during the birth of her first child. She had not actually sought psychological treatment at that time, because she assumed that something purely medical was wrong. She complained to her attending physician at the time, and he instructed her that she would get over her depression after a few weeks. When she did not, she was hospitalized for a brief period on the psychiatric unit of a local general hospital. She remembers finding no relief from that treatment at all, even though she remembers the staff being very nice to her, and frequently telling her that she was "being too hard on herself" with respect to the adequacy of her care of her first-born child. That depression began to lift when the first-born child was about two years of age. Mother C had seen a counselor during college years, but found that work to be empty, as she simply used her extraordinary capacity for attunement and for making herself pleasing to set up a relationship with that counselor in which she was quite completely in control. She eventually left that work without the problem ever having been identified, much less addressed. Mother D had seen a great many counselors over the years, none of whom had apparently identified the disorder as related to her development in the home of a narcissistic or borderline mother. She sought out counselors from a great many different fields, found many of them to be nice but unhelpful, usually found herself gaining the upper hand in the therapeutic relationship rather quickly, and ultimately left each therapy within a few months. She also became a devout follower of an Eastern religion, dabbled in radical feminist philosophy (principally, she said, to give herself the opportunity to be around other strong women and to "find out about women who have power."). SEEKING HELP The manner in which each of these four patients sought help for her depression, her anxiety and her upset regarding the current baby was of great interest. All

but one sought help exclusively for the baby, rather than for herself. The most common presenting problem was that the mother saw her parenting as being inadequate for the child, and she wished me to "save" her baby from herself. Reference was sometimes made to ". . . my poor baby, who really has no one, since I'm not really there for her," or for ". . . this kid, who is going to be a basket case, just like me, and all because of me." Mother A was referred by her physician after becoming extremely upset at the beginning of her third trimester of pregnancy, when she discovered she was having twins. As she had seen this therapist three years earlier (related to problems she believed her then-three-year-old daughter was having: extreme anxiety caused, according to the mother, by the child's maternal grandmother "driving her crazy," and by the fact that the child "had no father and needs a man to talk to"), she agreed to see him regarding her feelings about having twins. However, she proclaimed herself quite completely healed after one session, and resisted further contact. She did agree to continue seeing this therapist (to humor him, she said), until after the twins were born. It was at that time that she more actively sought his help, as she observed that her female twin was in agony, was crying all the time, and was digging vigorously at the back of her head (causing bloody sores)-all because, according to mother, the newborn girl was missing her father (the truck driver). Mother B entered therapy in the most clear-cut way, as a result of extreme postpartum depression following the birth of her second child, ultimately requiring hospitalization. Before seeking psychological help directly, however, she made a trek to the home of her mother and father in a distant city, leaving her husband and first-born child. Her mother, then, became more or less responsible for the care of the infant for that 30-day period during which the patient stayed with her parents. (She was 33 years old at the time.) She sought help during that period from a variety of professional caregivers, including an herbalist, a dietician, and her own mother's doctor. She did not actually enter psychotherapy until her baby was about ten months of age, and she entered the hospital about the time of her baby's first birthday. Mother C originally sought help from her family physician because of extreme worry that her baby would be defective. When it became apparent that the mother's worries were leading to extreme anxiety and depression and could not be handled in the course of routine prenatal medical care, the referral was made to this therapist, whereupon it became clear that the mother's worries about defects had a great deal to do with her sense of herself being defective and thereby "infecting" her baby. Mother D entered work with this therapist when her baby was nearly two years of age. She had seen a great many therapists over the years, before the birth of this child, but had been seeing some kind of psychiatric or psychological caregiver almost from the day of her first-born daughter's birth. She became profoundly depressed immediately upon that birth and, just as had been the case with Mother B, made a trek to a distant city-with her baby in tow but her husband back home-to live for several weeks with her own mother and father. (She was in her early 30s at the time.) Upon returning to her home area she saw a psychiatrist, who prescribed medication which made breastfeeding impossible, resulting in further guilt on the part of this mother about failing her daughter in yet another way. She also saw a psychologist suggested by this psychiatrist, and then sought out the help of a family counselor. In each of these cases she remained in treatment for only a few weeks. Upon calling this therapist, she conducted a rather extensive interview on the telephone regarding his qualifications, before agreeing to a first appointment. She reported that the reason she chose this therapist was that he was known as "the baby shrink" and might be better able than others to help her daughter (who was then nearly two years of age). She steadfastly declined to talk about her own life and her own feelings, except as they related very directly to her having failed her daughter, and to specific methods to make up for those failures and to stop what she saw as her daughter's inevitable slide into depression and misery. Only after several months of tedious work was this mother able to permit herself to begin speaking of her own life, and to consider the possibility that she had sought help for herself through her baby. One way or the other, then, each of these mothers found her way into psychotherapy by way of worries about her baby. The connection between the onset of depression and anxiety and the birth of the baby is central to the hypothesis that special problems may be experienced by a female child of a narcissistic or borderline parent, who is herself becoming a parent. The data from these four cases suggest that

the newborn's or fetus's availability as a transference object is an especially significant dynamic. It appears that two identities may be projected: A. The baby becomes mother's own ill parent. This transference seems to make the baby appear especially powerful, and to bring back in mother the hated powerlessness and sense of irreversible, no-way-to-win inadequacy, often especially evoked by the baby's crying. B. The baby becomes mother, herself, as a little child. In effect, the baby screams mother's own screams (quite literally, in the case of Mother A). The social attunement and interactive hypersensitivity typical of the borderline is employed with baby-potentially resulting in terrific parenting. It also results in such an extraordinary (but misguided) empathy for baby-as-mother that mother begins to feel-perhaps for the first time-a morsel of empathy for self-as-child. But since empathy for self was never allowed-was "trained out" of the little girl by the life-or-death requirement that she unceasingly attend to her ill parent, or risk abandonment-this re-experiencing of her own needs and her own pain, through her baby, results in acute self-hatred and rebuke. Depression is the inevitable result. The depression is further heightened by the creation of a vicious cycle: when mother "succeeds" with baby (by escaping her past long enough to provide unconditionally loving care) she experiences her own deprivation, feels angry at her parent, engages in desperate suppression of that feeling, and rebukes herself for being bad. When she "fails" with her baby by repeating the caregiving pattern of her own parent, she feels sorry for the baby (and for her baby-self), rebukes herself for being a bad mother, and slips into a very real agony about seeing her baby suffer in the same way she did. These dynamics are so subtle, and involve so much unconscious process, that clinical discovery is difficult. Significant errors in treatment are highly likely with the few patients displaying this syndrome unless we can differentiate the external features-depression, distress over being a "good enough" parent, and anxiety-from the more common "baby blues" and from the other postpartum depressions. RISKS TO THE INFANTS The most immediate risks to these four infants were those related to the profound clinical depression itself. Two of the mothers (A and B) were quite completely immobilized during the peak of their depression-a period lasting approximately four months. During that time they had great difficulty with short-term memory, focusing, planning, and organizing, such that even basic needs of the baby could sometimes not be met. On many days the mother was unable to remember when the baby had last been fed, or even what the proper food was for the baby at the time, much less how to go about the various steps of actually preparing a bottle or getting a jar of food ready. These two mothers found it difficult to drive during part of this time, and often found themselves lost while in the car or walking around the house, unable to remember where they were going, what they were supposed to be doing, or how they should proceed next. For the most part they were unable to anticipate the baby's needs, were sometimes unable to prevent harm to the baby, and were so fearful of something happening to the baby because of their depression that they became extremely anxious while handling the baby. One of the more subtle risks to these two babies during the peak depression period was related to the mother's intermittent decathexis of the baby. There were both maternal reports-and clinical observations-of the mother staring at her child but being quite completely unaware of him/her. There were frequent episodes in which the baby would cry out for the mother, and the mother would simply not be able to hear, much less to organize herself to respond. A final risk related to the clinical depression itself has to do with the infant's responses to loss of mother due to her hospitalization. Mother B's hospitalization occurred at the child's first birthday and lasted for slightly over one month. The child was, of course, well into the differentiation subphase, knew mother well, and was just beginning to develop object constancy. The effects of such separations, particularly when there are no reunions or other opportunities for reassurance during the separations-and when the substitute caregiving system is also enormously stressed and not necessarily able to meet the baby's needs-are well known. When a separation of over one month is exacerbated by several preceding months of intermittent decathexis, and at least two other briefer periods of separation (due to visits to the patient's mother's home, and one brief hospitalization before she came to this clinician's attention), the risks became significant. We must also consider the effects on the mother/infant relationship of mother's overwhelming sense of inadequacy, her certainty that anyone in the world could take care of her baby better

than she, and her consequent wish to give the baby away. While none of the four mothers in this current report actually did give her baby away, there were periods during which each was absolutely certain this would be best for everyone involved. Such decisions are normally accompanied by preparatory decathexis, perhaps sometimes connected with guilt and the behavioral sequelae of gaze avoidance, avoidance of intimate physical contact, and pretending that the baby is really someone else's. Another risk to these infants arises out of the extent to which their mothers manifested borderline or narcissistic features, themselves. Just as these patients were vulnerable to developing their own personality disorder arising out of their mother's narcissism or borderline illness, so their infants were vulnerable to their own developmentally inappropriate narcissism, arising out of terror that their needs would not be met, their awareness of the "terrifying aloneness" experienced when mother is not available, and their efforts to fend off the abandonment depression. If they responded principally with narcissistic desperation, we might have seen control struggles with mother, food hoarding, food refusal, and a difficult time with normal individuation as toddler and mother struggle for power. If they responded by being caught up in mother's narcissism, instead, they might have begun to repeat the desperate cycle (the cycle mother herself may or may not remember having once been caught up in) of trying to please mother in order to forestall abandonment. In this latter case, the developing child would have been likely to forget why he was engaging in such behavior, would have repressed any memory whatsoever of his fear of aloneness and abandonment, and would even have idealized mother as he struggled to make her happy with him.
PROBLEMS OF TREATMENT Treatment of the four patients described herein was exhausting. The matter was made more difficult by the fact that, for the most part, these four mothers did not come to treatment for themselves, but, rather, came either for their babies or directly because of the birth of their babies. Therefore, the work was complicated by a great lack of clarity about who the patient was, which, in combination with the paradoxical lack of empathy for self that characterizes many borderlines, meant that it was very difficult for the patient to turn attention to self. In actual fact, the clinician was worried about the baby in every case. A most tedious balance, then, had to be maintained between expressions of interest in the baby-and occasional work directly on mother's care of the baby-and expressions of interest in the mother herself. At the same time, however, the presence of the baby enormously enriched the work. For example, as the mothers spoke of their babies' feelings with considerable sensitivity, and offered worries about their babies' futures, it became possible to ask (much more directly than would have been the case had no baby been present) whether the mother knew any other babies who might have felt this way. While great care had to be taken in this regard, it also became possible to ask whether mother thought that her parent had taken a similar level of interest in her optimal development: whether anyone had worried about her, as the patient was now worrying about her own baby. There was always the constant risk, of course, that such a remark would provoke righteous defending of mother's mother, considerable regression in the patient's slow growth of empathy for self, apologies about earlier complaints about her own parent, and profound retrenchment. Each excursion into thinking about baby's needs and how to best meet them provoked great outpouring of feelings. This outpouring was actually for the self, often. But each of these mothers lost long ago the ability to attend to her own needs, to believe that it was permissible to have her own needs met unconditionally, and to see that she would not die or be abandoned if she allowed conscious awareness of the fact that there was something wrong in the way she was being cared for. Perhaps it was this great reservoir of feeling-which had nowhere to go because of the characteristic lack of self-empathy-that gave each of the mothers such an unusual sensitivity to her own child's feelings. And, perhaps, it was also each mother's experience of being cared for so badly that led to her determination to do it better this time-as well as to her extraordinary guilt when she saw herself failing. While each mother's preoccupation with her baby's feelings and needs and her failure to meet them was sometimes frustrating, it also could not be ignored, as this was often the only avenue to mother thinking about how babies in general feel, what things babies in general need, and, therefore, what mother missed. It was clear that it would not be possible for any of these mothers to begin to love their babies freely or care for them differently than their own

parents cared for themselves, unless the pain of their own infancy and toddler years could be explored and expressed, the abandonment depression released, and even some rage at their own borderline/narcissistic parents' behavior acknowledged. One mother summed up her frustration about maintaining this balance between looking at herself and looking at her daughter by saying, "But we can't wait for me to get better! She's growing up in this crazy house in which I can't stop myself from relating to her in ways that I know are bad." At another point this same patient-after I remarked on her determination to make it better for her baby than it had been for her-said, "Big deal! If I can't reverse all the damage I have already done to her and continue to do to her each day-as we work at getting me well, I'll have no excuse. What will I do when she's sixteen: show her my checkbook, to prove that I paid a therapist to help me help her?" Clinical methods employed included a model of treatment-via-themother developed by Fraiberg and colleagues at the University of Michigan (Fraiberg et al., 1980; Adelson &Fraiberg, 1977; Pawl &Pekarsky, 1983; Pawl, 1984; Lieberman &Pawl, 1984; Kalmanson &Lieberman, 1982) which calls for careful examination of infant-parent exchanges for clues about the nature of the disorder which threatens the infant's optimal development. Therapy was relatively short-term in each case (6 months-2 years), and less intensive than prescribed (1-2 times per week)-both due to financial constraints. Theories of treatment with borderline patients most closely manifested by this work were those of Masterson (1975, 1983) who treats transference (usually thought of as transference with the therapist; in these cases, that notion was extended to the transference with the baby) as a reflection of the patient's own real experience; and Buie &Adler (1982) who suggest that the therapist may need to temporarily become a stable holding self-object for the patient-with all that implies regarding availability: for example, for extra contact between sessions and during vacations. At one time or another with each of the four patients, it became a necessary part of the treatment to teach the patient how to ask for what she needed from the therapist. It was discovered that appointments were sometimes being cancelled because the patient feared that she did not have anything "good enough" to say that day, that she was afraid of being a bad patient (and, of course, of being abandoned because of that). When there was trouble setting up a new appointment time, the discovery was sometimes made that the patient was not being uncooperative, but was simply trying not to bother the therapist too much by stating clearly what would be the best time for her. Sometimes the patient was angry at the therapist because she had great need for him due to a particular crisis with the baby in the preceding few days, and had been unable to reach out for his help by way of a phone call. In each of these cases, it became necessary to wonder together about what would happen if needs were reported clearly, what the real fears were, and, of course, when these had been experienced before. This author lectures widely and is, therefore, gone from the office from time to time. While this was always a great worry during the treatment of these four patients-and while it did seem to be related to serious regressions more than once-these departures also created opportunities for profound work. While it was common for each of these patients to give her fullest "permission" for the therapist to be gone and to report vigorously that this would present no problem to her, each eventually learned to tell the truth. Some learned to say that such departures felt familiar, others learned to express anger at separations, and some even learned to take action to meet needs during such separations. Sometimes the therapist would call the patient while away; at other times, arrangements were made for the patient to callan experience in exerting non-defensive control over meeting her own needs. These experiences were often surprising to the patient, although they were always prearranged, and seemed to be small corrective experiences that directly addressed object constancy insufficiencies and abandonment fears. Another dilemma in this clinical work lies in the maintenance of a very delicate balance in the patient's attachment to the therapist. Attachments were both yearned for and vigorously defended against by each of these mothers. The acuteness of the depression, the fact that a baby was about to be born or had just been born, and the mother's extraordinary vulnerability to understanding how babies feel seemed to lead to a stronger and earlier attachment to the therapist in all four of these cases. This was a great danger to each patient, of course, as such attachments carried for her the risk of loss and abandonment. Each of these patients imagined-and

several of them spoke articulately about the matter-that the therapist would abandon her, use or manipulate her, "play with my feelings," and eventually throw her away. All of the testing about the therapist's dedication, loyalty, and intelligence became much more understandable as these defenses became apparent. However, the defenses were not effective overall, as each patient came to see that they only prohibited her from having what she had wanted for so long: a trusting engagement with someone who could be available (in an admittedly contrived and limited way) in a way that was more pure and unconditional than any engagement experienced earlier. Since the threat of abandonment always lay just around the corner for these patients, abandonment depression also was a constant threat to them. Each of them seemed to know that she had probably been at risk for serious depression all of her life, although that had only become acute enough to be attended to during the pregnancy for or the birth of her baby. Each patient was, then, stuck in a terrible dilemma: To allow herself to trust the therapist, to invest fully in the work, or to experience any kind of attachment with the therapist carried with it the great risk of loss and, paradoxically, becoming more depressed than she had been in the first place. However, if she failed to develop this kind of trust, or failed to engage fully in the relationship and in the work, each seemed to know that one of the clearest opportunities to grow up, to separate from her own parent and from her own infancy, and to throw off the smothering cloak of her own mother's narcissism, would be lost. Some of the patients handled this paradox by suddenly "getting well," reporting complete alleviation of symptoms and newfound successes in caring for baby-and adding profuse expressions of appreciation to the therapist for his help. One of the four patients succeeded in terminating work in this way, only to come back four months later, furious at the therapist for having let her go. Others handled the paradox with constant cycling about their worries: declaring on one day the most profound concern about the baby and a glimmer of empathy for self, then reversing all of that the next week by declaring that she was exaggerating the week before, that other people must have it much worse off than she, that sometimes she feels like such a silly little girl to complain about such small things. While this cycling often appeared to be part of the patient's rather desperate need to protect her own parent and to never complain, it also seemed to be part of a quite understandable resistance to an attachment and a work that simultaneously offered the possibility of healing and the possibility of utter destruction. TREATMENT RESULTS In these infant mental health interventions, it was the well-being of the baby that was considered central. Mother was the focus of treatment in each case, but for the sake of baby. Mother A-whose anxiety and depression began during the pregnancy, immediately upon the discovery that she was having twinshas grown beyond her transferential relationship with the female half of that twinship. Almost immediately after the videotaped session described in this paper (in which the infant seems to scream her mother's screams for her) the infant twin stopped screaming, began to gain weight, began to engage in the social smiling and looking that had been missing before, and began to look like the well-developed and physically healthy baby her twin brother had been all along. Mother appears to have orchestrated her husband's firing from his truck-driving position-a remarkable testimony to this patient's ambivalent wish to both have her husband be away (preferably such that he could come and go unpredictably, just as her father had) and that he actually be with her (thus reversing history). Marital disputes, occasional marital separations, and family strife continued, as mother struggled with her fears of abandonment, her terror at being fully engaged in any relationship, and her hypersensitivity to the failures of everyone around her. However, her care of the children became much warmer, and she was able to support them in their normal development. She struggled to set limits on her own mother's continuing intrusions into her life, gave up some of her overwhelming need to be always in control, permitted some normal grieving for the loss of her father, and eventually moved to another town with her husband and children, "... since that's the only way I'm ever going to have a life of my own, away from my mother's control." Clearly a borderline herself, she is a long way from being healed; but her baby is now safer. Mother B, who became so profoundly depressed after the birth of her son that she had to be hospitalized, began to experience relief from her depression when the child was about 18 months of age. Along with that relief came strong feelings of attachment to him. She learned to set limits on her own mother

(particularly as related to holiday demands), to be clearer with her husband about her wish to not have him be gone all the time, and to terminate her excessive involvement with a homemerchandising system that rather cleverly played on her needs to please another woman in authority. Mother C, whose depression and anxiety began during her pregnancy, and who worried so about the birth of a defective child-bore an unusually attractive and responsive female infant, to whom she eventually developed a profound attachment. Her attunement to this infant was sometimes startling, and she was eventually able to turn that same kind of sensitivity on herself. She slowly began to understand that she had been a psychologically abused child, and that her vague and elusive awareness of the fact made it no less serious. She eventually stopped comparing herself to "children who really have it toughyou know, the ones who get hit by their parents or who are actually physically left by their parents forever," and allowed herself to give credibility to her own sense of having been wronged. While she initially put her infant in the care of her own mother, she eventually began to see that there was no need to torment herself with daily observations of her mother's ability to do much better with her granddaughter than she had with her daughter, nor was there any particular point in giving her mother a chance to do a better job the second time. She began to "come out of the closet" with her two brothers, to discuss openly with them what it had been like to be children in that household. Her two brothers had, of course, experienced a somewhat different mother, but the patient was able to appreciate that this did not change what had been her experience, and that she did not need confirmation from someone else to prove that she felt the way she felt. She eventually began to set up clear contingencies with her mother, to walk out of the house if her mother began abusing her again, and to even speak with her father about why he had not done a better job of protecting her. When her own psychological growth lead to marital problems (as it often does, since the newly healing patient has a different set of needs, will not necessarily put up with the same sorts of things she once thought she was condemned to live with, and may have a much better ability to acknowledge and report her own needs), she entered marital therapy with her husband-thereby expressing her determination to hold on to things that were precious to her, rather than throw away all those things that were a danger to her. Mother D, who is still in treatment (and is one of only two of the four patients who has clearly developed the borderline illness, herself,), began to experience some alleviation of the depression when her child was about two. She has remained in therapy for over a year (several times longer than she ever has before), and is slowly giving up some of her intellectualizing, constant testing of the therapist, and her impulses to run away. Her husband is still in the distant state and she is struggling with the decision about whether to join him there or to make clear to him that she wants him to return here. All four patients, then, experienced relief from anxiety and depression, although it is not clear to what extent psychotherapy contributed to this relief or shortened the duration of the depression portions of the larger problem. Based on the experience of Mother B after the birth of her first-born, symptoms might have begun to fade even without psychotherapy, in about two years. Mothers A and D-who most clearly displayed the borderline illness themselves-made significant improvements in their interpersonal relationships, in affective stability, in the development of identities separate from others, and in their management of anger. In their brief therapy, personality restructuring could not occur, however, and much work remains. Perhaps more to the point of this type of limited intervention on behalf of the baby, all four mothers were able to develop warm, synchronous relationships with their babies, free of the projective identifications to which these relationships had earlier been subjected. These babies gained mothers able to differentiate empathy-for-self from empathy-for-baby, without losing the extraordinary attunement each had once manifested (albeit pathologically). No unmanageable depressive relapses were experienced, although Mothers A and D occasionally displayed manic states. Three of the four babies have moved through rapprochement with a supportive and appropriately invested mother nearby. (Mother A moved, and no report is available on the progress of her female twin through this developmental period.) The comparison of the relatively unconditional nature of each mother's emotional availability with that which she experienced as an infant is striking-and may mean that these children will not have to repeat the patterns of the past with their babies. DISCUSSION This paper described a clinical

intervention with four patients who seem to have shared a number of early life experiences-particularly characteristics of their own mothers and their relationships with them-and who also shared a number of symptoms (which emerged, in each case, around the birth of their babies). Depression was the predominant symptom in each case, but some features of narcissistic or borderline personality disorder also characterized each of these patients, and each of their mothers. It is hoped that the current report will aid our attempts to differentiate the varieties of perinatal depression, to consider the data more carefully as we make our assessments, to consider the birth of the baby as more than a biological phenomenon with hormonal overtones, and to respect etiology as absolutely critical in the choice of treatments. An effort has been made to describe the risks to the infant, not only related to the profound clinical depression, but to the narcissistic/borderline features themselves. The fact that two of the mothers had birthed one baby each prior to the delivery that brought them into care-and that each reported having "felt just the same way then as I do now, but I didn't get help"-seems to suggest the extraordinary need to assist mothers by carefully diagnosing and treating this type of illness-since clearly it will return upon the birth of a next baby, if it is not treated. Effort has also been made to describe the vicissitudes of treatment of this syndrome, but certainly not to discourage the clinician who takes on this exhausting but most exhilarating task. Rarely in clinical practice do we have such a dramatic opportunity to aid a patient in the discovery of her true self, to be an ally in her finding liberation from her own mother's narcissistic manipulations of her as a child (which have often continued-either in reality, or through the introjected parent), and to help her create non-neurotic defenses against depression. For us to also have the opportunity to profoundly affect the psychological future of the infant through whom mother came to treatment in the first place, makes this a challenge worthy of our best assessment and treatment efforts. References REFERENCES Adelson, E., &Fraiberg, S. (1977), An abandoned mother, an abandoned baby. Bulletin of the Menninger Clinic, 41(2):162-180. Buie, D., &Adler, G. (1982), The definitive treatment of the borderline patient. International Journal of Psychoanalytic Psychotherapy, 9:51-87. Chesick, R. (1977), Intensive Psychotherapy of the Borderline Patient. New York: Jason Aronson. Fraiberg, S., Shapiro, V., &Cherniss, D. (1980), Treatment Modalities. In S. Fraiberg (Ed.), Clinical studies in infant mental health. New York: Basic Books, 49-77. Giovacchini, P. (1979), Treatment of Primitive Mental States. New York: Jason Aronson. Gunderson, J. (1984), Borderline Personality Disorder. Washington, D.C.: American Psychiatric Press. Kernberg, O. (1975), Borderline Conditions and Pathological Narcissism. New York: Jason Aronson. Kalmanson, B., &Lieberman, A. (1982, October), Removing obstacles to attachment: Infant-parent psychotherapy with an adolescent mother and her baby. Zero to Three, 3(1):10-13. Lieberman, A., &Pawl, J. (1984), Searching for the best interests of the child: Intervention with an abusive mother and her toddler. Psychoanalytic Study of the Child, 39:527-548. Mahler, M., Pine, F., &Bergman, A. (1975), The Psychological Birth of the Human Infant New York: Basic Books. Masterson, J. (1972), Treatment of the Borderline Adolescent: A Developmental Approach. New York: John Wiley &Sons. Masterson, J. (1983), Countertransference and Psychotherapeutic Technique. New York: Brunner/Mazel. Masterson, J., &Rinsley, D. (1975), The borderline syndrome: The role of the mother in the genesis and psychic structure of the borderline personality. International Journal of Psychoanalysis, 56:163-177. Pauleikhoff, B. (1987), Post-partum major depressive illness. Marci Society Bulletin, Summer, pp. 43-47. Pawl, J. (1984), Strategies of intervention. Child Abuse and Neglect, 8:261-270. Pawl, J., &Pekarsky, J. (1983), Infant-parent psychotherapy: A family in crisis. In S. Provence (Ed.), Infants and Parents: Clinical case Reports. New York: International Universities Press, 39-84. Trout, M. (1986), "The Psychological Dimensions of Pregnancy and Delivery," Unit II in the videotape series, The Awakening and Growth of the Human: Studies in Infant Mental Health. Champaign, Illinois: The Infant-Parent Institute. Waldinger, R., &Gunderson, J. (1987), Effective Psychotherapy with Borderline Patients. New York: Macmillan Publishing Co. AuthorAffiliation Michael Trout, M.A. AuthorAffiliation The author is Director of The Infant-Parent Institute, Champaign, Illinois. The Institute specializes in research, training and clinical services to families, related to disorders of attachment. Address correspondence to the author at 328 North Neil, Champaign, IL 61820.

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