

Pre- and Postnatal Repercussions of Handicapping Conditions upon the Narcissistic Line of Development

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Full Text: Headnote ABSTRACT: In this paper, I examine narcissistic difficulties experienced by the handicapped youngster, especially to the extent that they are anchored in pre-, peri- and early post-natal experiences that were cast in the molds of parental narcissistic vulnerability and of impediments to the infantile attainment of a core sense of self. Considerations pertain to relatively generalizable consequences of infant handicap, encompassing the potential effects upon narcissism of a broad range of developmental disabilities. The use of the term "narcissism" in this text, with reference to both adults and infants, is concordant with the definition of Stolorow and Lachmann (1980): "mental activity is narcissistic to the degree that its function is to maintain the cohesion, stability, and positive affective coloring of the self representation" (p. 26). However, the perspective on narcissism adopted in the present paper is broader than a specifically self-psychological view, because it recognizes the validity of multiple psychologies (cf. Pine, 1988), including drive/conflictual, ego-psychological and object-relational as well as self-psychological models, to properly account for the clinical and observational data. Moreover, body-anchored primary narcissism is differentiated from secondary narcissism as a consequence of relations with anaclitic objects (Kestenberg & Borowitz, 1983, 1989). THE COALESCENCE OF INFANT AND PARENTAL NARCISSISM Impediments to the actualization of each of the narcissistic configurations proposed by Kohut (1971)-the grandiose self and the idealized parent imago-are intrinsic to the infant born with a congenital or peri- or postnatally-acquired deficit. The often profound impact of the infant's condition upon the narcissism of each parent delimits the degree and quality of a "confirmatory echoing" (p. 124) and approval of the child that is elemental to salutary mirroring. The jarring experience of parenting a developmentally disabled newborn can have profound impact upon the most basic interactions between parent and child. Whereas for the healthy baby, some manner of "gleam" in the parent's eye is usually readily fashioned in response to the infant's bodily display, the impaired baby is at a disadvantage in eliciting adequate narcissistic supplies. The parent of a developmentally handicapped youngster is challenged to re-discover this gleam to offer the child in the process of encouraging potentialities. There is a growing understanding of the importance of the intricate nonverbal reciprocal and mutual influences that infant and parent have upon one another (Lichtenberg, 1981; Beebe, 1984; Stern, 1985; Kestenberg, 1985), and of the significance of the qualities of harmony, adjustment and synchrony in the manner of dialogue achieved. It is in the developmental context of "interlocking responsivity" and "finegrained attunement" (Beebe, 1984) that early psychic structuralization takes place. Such considerations led Atwood and Stolorow (1984) to expand upon Kohut's self-object concept and to delineate the idea of an intersubjective field that evolves through progressive developmental phases, beginning prenatally. The preparation for the embryo to emerge as neonate depends in large part upon the interplay between its biological system and innate developmental patterning and that of the mother. The mother's preparation is also profoundly influenced by the specific psychological meanings the newcomer has for her as her experience of the pregnancy is assimilated into the already existing structure of her sense of self, including especially, her body self. To harbor within her body a new living and parasitic entity with its absolute dependence, to have her body change radically in ways that cannot be controlled, to realize that her life will never again be the same and now contains a new and central uncertainty-all of these changes require significant reorganization of her subjective world (Atwood & Stolorow, 1984, pp. 70-71). The developmental attainment of hale narcissism, as in the attainment of a "nuclear self", depends upon the relation

between parental expectations and the developing self of the baby. It derives from a process that originates prenatally, and possibly preconceptually, for its beginnings lie, according to Kohut and Wolf (1978, p. 417) with: specific hopes, dreams and expectations concerning the future child in the minds of the parents, especially the mother. When the baby is born, the encounter with the child's actual structural and functional biological equipment will, of course, influence the imagery about its future personality that had been formed by the parents. My own follow-up of children who were diagnosed at or soon after birth with neurodevelopmentally related problems finds a proneness, several years later, to extreme sensitivity to failures, criticism and disappointments. A defective sense of self often becomes central characterologically. This appears multiply determined: as a consequence of deficient supplies of primary narcissism in earliest experience, compounded by excessive primary masochism (Kestenberg & Borowitz, 1983), along with deficits in both mirroring and idealized parent-imago self-objects (cf. Kohut & Wolf, 1978). The infant who becomes the object of anticipatory anxiety and concern may not have his or her vigor and wholeness confirmed. Analogously, the calmness and omnipotence that are intrinsic to the idealized self-object are quite often less than they would otherwise be, in light of parental reactions-of powerlessness, victimization, frustration and sometimes guilt. Handicapped infants are all the more susceptible to early disturbances in self-development because the mirroring and idealizing needs are too often insufficiently responded to, hence, the "transmuting internalization" process, which goes into crystallizing the self, is deflected and encumbered. Recognition of an infant's handicapping condition can often impair the reorganization of the mother's subjective world, and derail the processes that are integral to the intersubjective field, contributing to the secondary-narcissistic vulnerability of the impaired infant. The risk to the infant is amalgamated with the risk to the parent of failing to cope with the child's condition, which is in turn a function, in part, of the relative health of each parent's narcissism. In this context, "narcissism" applies to the ability one has to regulate self-esteem in such a way that he or she is not completely dependent on the outside to validate or confirm one's own self and personhood. Such health is not negated by manifestations of "adaptive" depression and denial in the face of the infant's diagnosis (Charone-Sossin & Sossin, 1987). Winnicott (1960) stressed the role of maternal care in establishing the conditions for the infant to psychologically "be," i.e. for the "inherited potential" of an infant to "become" an individual in his or her own right. The central self could be said to be the inherited potential which is experiencing a continuity of being, and acquiring in its own way and at its own speed a personal psychic reality and a personal body scheme (p. 590). A continuity of being evolves in the context of a holding environment, which functions to cause a reduction "to a minimum of impingements to which the infant must react with resultant annihilation of personal being" (p. 590). The essential maternal role of providing "a live adaptation to the infant's needs" (p. 594) is grounded, in Winnicott's view, in the mother's identification of herself with her infant. The manner in which physical and psychic support is offered by different patterns of actual holding-fostering relative degrees of stabilization, motility and mutuality (Kestenberg & Buelte, 1977a, b; Romer & Sossin, 1990)-may be paradigmatic of the more encompassing holding environment. At birth, a healthy, "idealizable" baby can offer a mother narcissistic gratification and can help promote resolution of the conflicts intrinsic to pregnancy. Conversely, a non-perfect baby can bring narcissistic injury by deflating the mother's sense of self. A restoration of narcissistic balance (Reich, 1953) by the mother, through identification with the baby, may not be available when the baby's deficits are significant. The self-representation of either parent may be negatively characterized by feelings of devaluation, failure, vulnerability, and feelings of getting less than one is entitled to. Furthermore, the parents may see disavowed aspects of themselves in the handicapped infant. Lax (1972) described how: ". . . the mother feels as if she created what she always, unconsciously, felt she is rather than what she hoped for. . . . the mother unconsciously perceives the child as an externalization of her defective self and the extent to which the mother is simultaneously symbiotically linked to her child" (p. 340). When the baby is impaired, the mother's perception of the baby may regress to an earlier stage, when the baby was a part of herself, thus intensifying her feeling that she herself is damaged. Or, another mother may return to her initial perception of the fetus as a foreign "other-than-me"

phenomenon from which she can retreat in anger and dismay, disclaiming her initial tie. When the fetus or baby is deemed at serious risk, expectant or post-birth parents generally experience a severe injury to their own sense of self worth (Roos, 1963; Mitzner, Als, Tronick & Brazelton, 1984; Herzog, 1982). The parental emotional reactions of loss of self-esteem, shame, ambivalence, depression, and an increased need for self-sacrifice are magnified by prior narcissistic vulnerabilities. A mother of a child with a serious metabolic disorder described her renewed feeling of "being the baby my parents never wanted." A mother of a child with Down's syndrome reexperienced her own childhood feelings of "not being intelligent enough"-she became frozen in self-doubt, unable to make any decision in major areas of her life. CASE 1 Two-year-old Paula suffered spina bifida. She was of normal verbal intelligence; she could enter into a broad range of affective exchange facially, and evolved a solid base of verbalization. I refer to her to discuss the role of denial in the parent and its impact in regulating the sense of self in the child. This child's mother became expert at every aspect of her complicated child's life, which included her therapy and tube (gavage) feedings. Mother took classes and became certified in various aspects of her care-and was in fact a teacher of other parents. She became an ardent advocate of her child and those with similar disabilities. Doctors insisted that her daughter experienced no sensation in her legs; she refused to accept that assessment, using a fleeting patterned reflex as evidence for her contention that there was sensation. The mother endeavored to see her daughter as "whole;" though certainly drawing upon healthy aspects of attachment and love, contributing to constructive advocacy, Paula's mother was also drawing upon defenses protecting her own sense of fragility. She identified strongly with Paula, for she too had a childhood condition requiring extensive medical involvement, leaving her stigmatized as an adult and as a single mother. For this mother, her daughter's condition, though grievous and stressful, was a catalyst to the mother's enhancement of her own esteem, sense of purpose and efficacy. Because Paula was so able to define her own mother's meaning, the mother was especially able to infuse her daughter with positive regard-elevating the narcissism of both. Over the course of the next few years, this "adaptation" began to miscarry to some degree as separation struggles ensued, heightened by Paula's degree of physical dependency; the mother's esteem remained excessively anchored in her caregiving role, diminished by dissolution of her denial system, as the lasting nature of her daughter's motor deficits became clearer. Mother developed extremely strong pregnancy wishes, in part through her effort to resolve her renewed quandary pertaining to self-worth. The capacity to parent in a manner likely to enhance the narcissistic development of the child is partly a function of the extent to which a parent views the infant as a negative part of him- or herself; i.e. as an embodiment of his or her own inadequacies. Adaptively, a parent needs to view the infant as separate and not as a negative extension of the self, yet identification is intrinsic to attunement and the mutual influence processes. A focus on the infant's specific abilities and patterns of individuality and cuing help to foster recognition of the infant as separate. (This is a key, though sometimes unfulfilled, role of infant intervention programs.) For both the impaired infant and his or her parents, there are impediments to the processes of reciprocal engagement, communication and mutual influence. Hence, there is heightened vulnerability due to failures in the holding environment. As Modell (1984) discussed in relation to parents who could not offer positive mirroring based upon the communication of genuine affects, the result for the developing child can be a "psychic cocoon" (p. 39), in which the self is sustained by omnipotent fantasies to the degree that the environment is perceived as nonprotective and untrustworthy. In such instances, the sense of self is extremely fragile, separation is obstructed and intense yearnings to merge and fears of engulfment may become prominent. The development of empathy and trust between infant and primary caregiver and the finetuning that occurs in the normal dyadic relationship has been highlighted by numerous writers (Beebe & Gerstman, 1980; Kestenberg, 1975; Kestenberg & Buelte, 1977a, b, 1983; Stern, 1971). Serious handicaps on the part of the infant lead to an interference in this interaction, and trust is not elicited. To the extent that the regulation of excitation, arousal, activation, stimulation, and tension are atypical amongst specific handicapped babies, there is a high risk for disturbance in what Stern (1985) calls "core-relatedness" between parent and infant. The infant's unresponsiveness, disengagement and frequent distress

may take their toll on the mother, exacerbating her depression and leading to her disengagement from the infant (depleting the infant's resources for his or her own secondary narcissism).

PROBLEMS OF MIRRORING AND REGULATING STIMULATION

Excessive parental depression and/or rejection can lead to an understimulation of the infant resulting in extensive unmirrored experience and a resultant empty-depression in the child. Our neuropsychological perspectives in the ongoing assessment of handicapped youngsters often cloak the dynamic and interpersonal underpinnings of some repetitive, self-stimulatory behaviors exhibited by the afflicted child. The parental self-objects can also be overstimulating, especially as they are driven by fantasies that may be unrealistic, compensatory and/or grandiose, anchored in excessive denial or powerful undoing wishes. In our essentially benevolent eagerness to promote the role of parents as the primary "therapeutic agents" in the context of infant-intervention programs, we sometimes find ourselves unwittingly reinforcing such overstimulation. Conceptually, the problem of overstimulation especially develops when the parental responses focus prematurely and unrealistically on fantasied performance and products, and inadequately on the "exhibitionism of the nascent nuclear self of the child as the initiator of the performance and as the shaper of products" (Kohut & Wolf, 1978). Simply put, empathic parental stimulation will enhance, but unempathic stimulation will diminish, the handicapped infant's capacity for enthusiasm, initiation and whatever style of creativity he or she is potentially capable of.

THE APPLICATION OF MOVEMENT OBSERVATION

Methods of recording and conceptualizing nonverbal behavior are evolving that aid in the implementation of discriminating observation and appraisal of earliest interaction. Applying a complex, Laban-derived notational and classificatory system (Kestenberg, 1975; Kestenberg & Sossin, 1979) to the discrimination of infant and parent movement patterns [the Kestenberg Movement Profile, or KMP], two interdependent developmental lines are distinguished. In one, tension-flow rhythms and attributes reflect basic drive and affectual processes; these developmentally provide the underpinning of other patterns which reflect attitudes to space, weight and time. In another, shape-flow patterns, signifying basic feelings of comfort and discomfort (bipolar) as well as attraction and repulsion (unipolar), provide the underpinning to shaping patterns in three dimensions, reflecting complex relationships. Within this perspective, empathy derives from attunement in tension-flow and the development of trust evolves from mutual adjustment in shape-flow (Kestenberg & Buelte, 1977a, b; Kestenberg, 1985). Analogs of self-feelings (Kohut, 1971) seem to be especially reflected by the comfort, joy and elation of taking in (through widening, lengthening or bulging), and by the discomfort, pain and dejection of expelling and emptying (through narrowing, shortening and hollowing). Bipolar movements involving these patterns seem to bear upon the concept of primary narcissism, while unipolar movements involving these patterns, reflective of approach and withdrawal from caregivers, bear upon the concept of secondary narcissism (cf. Kestenberg & Borowitz, 1983).

THE IMPACT OF MOTOR DEFICITS IN EARLIEST INFANCY

The infant who is cognitively aware-but unable to head-right, come to sit, use a pincer grasp in prehension tasks, or then to come to stand and walk-is, given fine and gross motor deficits (relative to developing cognitive schemata perhaps), obstructed from experiencing early efficacy, mastery and "infantile locus of control" that are basic elements in the normal infusion of healthy narcissism.

Tension-Flow Rhythms and Attributes

Free-flow of tension promotes continuity and feelings of safety, but also loss of control; bound flow promotes discontinuity, but also feelings of control (Kestenberg, 1975; Kestenberg & Sossin, 1979). This elasticity is manifest in continuously (and often repetitively) rhythmic alternations that are particularly manifest in relation to drives, needs and states specific to developmental phases. A prominent disturbance of such rhythmicity is evident in the baby that cannot adequately suck, either because of aberrant muscle tone or because of suck-swallow reflex dysfunction; i.e. the functional "oral-libidinal" rhythm, showing smooth sinus-curve like alternations between free and bound flow, is not available.

Shape-Flow Rhythms and Attributes

The individual makes and breaks contact with the environment, its objects and qualities, through self-regulatory shape-flow: the manner in which the body grows and shrinks. The feelings of safety and danger evoked by tension-flow are objectified through shape-flow in moodfeelings of comfort and discomfort in the case of symmetrical patterns, or in attraction and repulsion in the case of asymmetrical

patterns. Kestenberg (1965; Kestenberg & Borowitz, 1983) has linked bipolar shape-flow with primary narcissism, in its creation of an undifferentiated image of self and object. Unipolar shape-flow has been linked with the development of secondary narcissism; objects are sought, and objects are withdrawn from. Matching of Tension and Shape-Flow Factors Following Kestenberg (1975), the lack of certain flow factors can seriously compromise the child's success at the unfolding tasks of each developmental phase. Deficits in 'oral' (libidinal and sadistic) rhythms compromise the development of a primary system of communication between mother and child; deficits in 'horizontal' shape-flow compromise the adequacy of the prehension-release system, and of the attainment of a sense of constancy of space. A lack of 'anal' rhythmicity and associated 'intensity' tension-flow factors and 'vertical' shape-flow patterns compromises the attainment between mother and child of balancing stabilization with mobilization; a constancy of weight may not adequately develop. Similarly, the attainment of constancy of time is dependent upon harmonizing 'urethral' tension-flow patterns, associated attributes (graduality and abruptness) and related 'sagittal' shape-flow patterns. In each case, impairments, such as the lack of adequate sucking, deprive the infant of a basic sense of agency, so integral to healthy narcissism, and the earliest acquisition of a sense of self. Moreover, the rhythmicity of free to bound to free flow (and so on) is elemental to the acquisition of a core sense of self-continuity. An overabundance of derailed or phase-inappropriate rhythms, or a loss of elasticity in excessive neutral flow or rigidity, promote feelings of discontinuity and impede the process of self-structuralization.

Handicapping Conditions In the case of neurodevelopmental impairments, or in the case of medical conditions involving pain or a lack of supplies, such as respiratory distress, cardiac insufficiency or perinatal injury, inner noxious stimuli act as catalysts for both tension- and shape-flow changes, generally involving bound tension-flow and shrinking shape-flow. The growing-shrinking patterns are psychomotor underpinnings of primary narcissism. The shrinking reflects the discomfort and serves to expel (Kestenberg & Brenner, 1987). Primary narcissism is compromised by degrees of deficient vitality and heightened dependency, as well as a relative lack of affirmation by parents and other potential suppliers of validation. The excessive shrinking often observed in the impaired infant lays the psychomotor ground for later feelings of deflation, emptiness and insecurity.

Compromising the Holding Situation A host of factors can hinder the adequacy or beneficial nature of the holding experience. These include: the parent's narcissistic wound, and its exacerbation upon tactile contact; the lack of reciprocity from the child (i.e. the mother of a disabled youngster cannot rely on the same clarity of cues and reinforcements as is the case with a healthy youngster); the pragmatic difficulty of holding a baby with aberrant muscle tone or atypical movement patterns, such as heightened intensity or pronounced shrinking; and the skewed nature of adjustment-it is often the adult who must do substantially more of the adjusting in shape-flow, as the involved infant is often responding to inner stimuli that interfere in the exchange between caregiver and him- or herself. The infant may not mold or cuddle. The resultant holding failure may then do further harm to the infant's narcissism, compounding the child's inherent difficulties with issues bearing upon self-reliance.

THE EARLIEST DEVELOPMENT OF SELF Winnicott (1955) referred to the fetus' kick against the mother's womb as offering the child a first feeling of "Me" and "Not-me." From this perspective, behavior is brought into experience through motility which finds appropriate opposition. The creation of boundaries generally involves some modality of aggression (from a drive-theory perspective), and the handicapped infant is at times impaired in establishing such boundaries. From the perspective of Kestenberg and Borowitz (1989), we would ask if there is an optimal amount of primary or secondary masochism necessary for the formation of such boundaries. Attachment theorists have described the development of internal working models of self and attachment figures (Bowlby, 1973; Bretherton, 1990) that are constructed from the actual transaction patterns between infant and caregiver and that predict the partner's behavior. The degree to which a mother notices, accurately interprets and appropriately responds to her infant's signals, i.e. her "maternal sensitivity" (Ainsworth, et al., 1974), is in part a function of her development of an internal working model of self as parent. Deficient communication patterns would be expected to lead to inadequate internal working models of the self and of the attachment partner for both parent

and child (Bretherton, 1990). The parent's prenatal anticipatory working model, even if relatively coherent and organized, is nonetheless strained to adapt to the extraordinary task of providing parental sensitivity and empathic feedback when the infant's signals are limited or distorted by neurodevelopmental impairment. Applying microanalytic techniques, Beebe (1984; Beebe & Stern, 1977) and others have demonstrated the significance of one-half-second events in the regulation of mother-infant interaction. Focusing on behaviors such as direction of gaze, facial-mouth movements and head and body movements distinguished by their horizontal, vertical and sagittal directionality, Beebe (1984) operationalized the concepts of coaction by the pair and noncoaction wherein the turns alternate between mother and infant. The contextual "temporal pattern of connectedness" that arises influences the quality of emerging self- and object representations, and consequentially, have an impact on the developing infant's capacities for subjective intimacy and self-esteem (cf. Stern, 1985). Regarding normal infant development, Beebe and Lachmann (1988) describe the internalization of the dominant patterns of mutual influence, specifically the manner in which the temporal patterns of mother-infant coordination come to be represented and hence lead to anticipation and mutual regulation. Optimal contingent responsiveness to the cuing gestures of the handicapped infant is diminished as a function of both the infant, whose cuing may be atypical, and of the parent, whose own narcissistic injury may diminish adaptive responsiveness. The cognitive impairments of some infants also limit the capacity to schematize internally and to affectively represent the process of mutual adjustment. Related to the degree of impairment, the handicapped infant-caregiver dyad is at risk for failing to adequately internalize the temporal pattern of connectedness. CASE 2 Jane, a severely neurodevelopmentally involved child, diagnosed with spastic quadriplegia, was prone to states of incredible rigidity and hypertonic arching-though she was just as prone to states of neutral tension- and shape-flow. By most standards, the positive feedback to the mother was extremely minimal. Yet, partly due to the relatively healthy narcissism of the mother, this couple was able to achieve a degree of "interlocking responsiveness" or "attunement." Overall, mother was able to keep a remarkable balance between her powerful identification with her daughter and her recognition of her daughter's separateness. In terms of motor patterns, this was reflected by her capacity to attune to her child in neutral flow, somehow sustaining long periods of inanimateness without feeling too great a threat to her own sense of self. At the same time, this mother was able to guide her daughter to transitions and new acquisitions with properly timed and titrated stimulation. Through sameness of tension flow and mutual adjustment in shape-flow, nascent experiences of empathy and trust were experienced. Their temporal pattern was remarkable as well. Mother could, to a significant extent, match her daughter's graduality and abruptness, while providing for her stability and allowing mobility. Mother knew, and taught the professionals around her, that her daughter was capable of predictable stimulus-response behaviors (e.g. spatially orienting to a bell, if given enough time to do so). Efforts, especially deceleration, and their precursors, fostered attunement to her daughter, and thereby promoted this very disabled child's sense of agency and continuity. The mother's mirroring and adjustments in shape-flow promoted her daughter's sense of shared affects and of an intersubjective world. Indeed, these terms may be relatively applied, with qualifications, to such an involved youngster, but it seems nonetheless valid to speak of the role of narcissism and self-attainment, even in the case of such a severe disability.

POSTNATAL FACTORS CONTRIBUTING TO DISORDERS OF SELF-DEVELOPMENT AMONGST NEURODEVELOPMENTALLY IMPACTED CHILDREN

For Stern (1985), the organized subjective reality of a sense of self, in the form of a pattern of awareness, bearing upon how an individual experiences him- or herself in relation to others, occupies the central position in the study of the preverbal (and possibly pre-born) infant. The comprising senses of self that Stern describes as so elemental to normal social functioning are each compromised by neurodevelopmental impairment (across a wide band of severity obviously). From a phenomenological perspective, the impaired infant's perceptual and cognitive processes may also contribute to vulnerabilities along the narcissistic line of development (cf. Bach 1977; Akhtar & Thompson, 1982). Defects in perception of body-self, organization of thought and communication, intentionality, mood regulation and perception of time,

space and causality can significantly contribute to deficits in narcissistic development. Deficits in the sense of self, however, are often anchored far earlier in the earliest relationship—and related to inability to initiate or maintain social contact, failures of entrainment, attunement, coordination and adjustment between mother and infant, and the derailing of interactive rhythms. Both the coactive and turn-taking modes of interaction and communication may be fraught with clashes and mismatches, as functions of aberrant muscle tone, muscular dyscontrol, hampered affective expression and irregular rhythmicity in the infant, compounded by the impact upon the parent of narcissistic injury and reactive depression. Research has found that even in a nonclinical sample, relatively mild depression in mothers seems to diminish the child's motivation for challenge and mastery (Redding, et al., 1990); both the degree of maternal reactive depression and the need for high motivation in the child are often elevated in the case of the handicapped infant. To a greater or lesser extent, the handicapped infant is hampered in his or her acquisition of a sense of him- or herself as doer, actor, initiator and implementor—what Stern (1985) refers to as "a sense of agency." Research on normal infants has found that infants as young as three days old reliably turn their heads to the side of their own mother's breast milk (MacFarlane, 1975). Yet this finding is dependent on normal olfaction and normal muscle control; if either the sensory apparatus, the musculature or both are impaired then the infant cannot engage in this early act of recognition and finding. The infant with an impaired suck cannot enter into the reciprocity of the feed. The especially hyper- or hypotonic infant cannot enter into the mutual hold. The blind infant does not enter into mutual gaze. In each case, the sense of self-agency is diminished, delayed and distorted because of the inability of the infant to act on his or her own behalf. The infant's development of self (and of narcissism) will suffer over time as a loss of control to external agents gets repetitively experienced and reinforced. The infant with musculo-skeletal or neurological impairments is prone to fragmented body experience, compromising his or her "sense of physical cohesion" (Stern, 1985). While not wholly congruous, the conceptualizations of Stern and Kestenberg may be coupled in an attempt to more finely delineate the subsets of developmental self-experience. The infant's sense of temporal continuity and perpetuation rests upon his or her own experience of rhythmicity (especially as experienced in tension-flow and shape-flow patterns, within both isolated and interpersonal occasions). It is likely that this sense of self normally begins to emerge in utero. The dysrhythmic fetus-infant will be apt to have difficulty finding kinesthetic attunement in the uterine environment, in post-natal holding and in later parental care as well; this leads to a sense of discontinuity of other as well as of self. The impaired infant's experience of a high proportion of derailed, or especially constricted, rhythms limits the development of a sense of self-regulation over time of anticipatory schemata and of self-endurance. Kestenberg (1965) described an "inner core of self feeling" in relation to the alternation between free and bound flow. The child's "feeling of being" develops in the experience of being free, fluid and safe alternating with being bound, restrained and endangered. It is the rhythmic alternation of both of these states, and their repetition, that provides the infant with a core of experience of continuity and discontinuity. The narcissistic line of development for the impaired infant is compromised to the extent that the physical or mental disability that an infant has disturbs, distorts or inhibits the development of this inner core of self-feeling. From the perspective of the KMP, it may be suggested that one's "sense of affectivity" (Stern, 1985) grows with the ontogenesis of self-regulation of tension-flow and structuring shape-flow attributes. The impaired baby often does not experience the range of feelings from safety to danger (free flow to bound flow) and comfort to discomfort (growing to shrinking) that the normal baby does, nor are feelings as "confirmed" through attunement experiences with mother, as these are harder to attain. Excessive neutral flow can also restrict attunement experiences. The sense of a subjective self that can achieve intersubjectivity with another. For Stern (1985), this sense of a subjective self begins to develop at around nine months. We can view its precursors, however, as involving the extent to which attunement and adjustment can be attained in interaction. Kestenberg and Buelte (1977a,b) and Kestenberg (1985) have described how empathy occurs when tension flow passes from one person to another; such harmonious transmission makes for attunement. Harmonious adjustment in shape-flow, as in breathing and aligning together in the mother's

support of the infant, is the basis of trust. We can see how an infant's impairment may impede or distort the flow of both empathy and trust. To picture the extreme, we might think of a spastic quadriplegic child (cf. Bobath & Bobath, 1975) dominated by rigidity at birth; we see stiffness, opisthotonos and extended legs in supine. Arms are retracted at the shoulders and flexed at the elbows; in prone, tonic extension suddenly changes to a total flexor pattern and the head can no longer be lifted. Here, the infant's abnormal tone impedes the flow of tension-flow and shape-flow and limits the degree of support the caretaker can offer. Moreover, the mother herself enters this interaction expressive of her own emotional state—quite often in the midst of a significant reactive depression. Hence, her own excess of bound and/or neutral tension-flow, along with her own shrinking shape-flow patterns, reflective of her narcissistic state, impede the attainment of attuned functioning even further. Affecting the Channel of Emotional Maternal Referencing Considering the "emotional availability" system in infancy (Emde & Sorce, 1983), involving both the infant and parent, and considering the breadth of affects experienced—and signals expressed—by the healthy infant (Emde, Gaensbauer & Harmon, 1976), we note disturbances in this system in handicapped infants and toddlers. The child is compromised in the ability to offer rewards to the caregiver (because of physical stigmata, state-dysregulation or lack of wished-for achievement, etc.). An infant normally looks at a parent's emotional response to determine his or her own. In the case of handicapping conditions, the parent often gives caution-inducing, and sometimes fear-eliciting cues. Hence, the early referencing process can increase the degree to which the child responds to new and uncertain situations with bound-flow and shrinking. In the case of the hypervigilant parent, the child's confidence and trust (in individuals other than the caregiver) may not grow adequately. The referencing process may then substitute for, instead of promote self-development. CASE 3 One such boy, Ryan, had a congenital heart defect (transposition of the great vessels) repaired soon after birth, and suffered some consequential neurodevelopmental impairment. He relied upon his mother in the referencing process in an exaggerated way. His affective gestures were often subtle, as in the lengthening around his eyes, but affects in this family were extremely constricted, and the tendency was to not confirm either positive or negative affects. The degree of parental depression was significant, and he too became depressed, without a clear sense of agency or efficacy. In an evaluative session, he seemed surprised at the intonation in my voice, and in turn, became more varied in his own expressive style. Mother had been hospitalized a few weeks prior to the birth in an effort to lengthen the pregnancy, and she had been understandably frightened of an early birth. After birth, contact between mother and son was limited, prior to the child's transfer to a different hospital because of his cyanotic condition. She reports: "I was foggy—I never had a chance to really let it sink in. I wondered what he looked like." The mother tells of how she was not allowed by others to express her sorrow over the birth experience and what followed. As Ryan grew older, he too was unable to express his frustrations. As a toddler, he showed heightened neutral flow in both tension and shape; and he was prone to shrinking shape-flow patterns, especially shortening. At six years of age, his difficulty with affective expression became evident symptomatically, as he became quite encopretic, prompting renewed psychological intervention. Multiply determined, and anchored in conflict, his encopretic symptom of "holding on" reflected his anger/ aggression, effort at control, denial of feelings as well as a yearning to hold on to significant others—for he truly felt empty. Normal shame and disgust feelings had not evolved; developmentally, Ryan was focused on having an impact upon those closest to him. His developing self-image was fraught with negative aspects, especially regarding his self-perceived weakness and small size. In his earliest infancy, Ryan was a child depleted of primary narcissism: the most basic functions—circulation, respiration, temperature—were not well regulated. With time, secondary narcissism was not able to compensate, due to the significant depression of both parents and influenced by their communication to him that what was inside him was not acceptable. CONCLUSIONS The infant suffering neurodevelopmental deficit is at significant risk for experiencing serious repercussions in the narcissistic line of development. This is not only a function of diminished esteem because of difficulties with later achievement, but also because of the primary narcissistic vulnerabilities bearing upon the earliest body experience and the earliest evolving patterns of interaction. The

risk of impaired narcissistic development is a function of several factors, including but not limited to the parent's adaptation and manner of influence. The clinical challenge is to assist both parent and child, as early as possible, in the habilitation of their mutual influence process and alloyed narcissistic developments. These have often gone awry due to the confluence of the infant's constitutional deficits, robbing the child of self-enhancing motoric experiences, and the impact of the parent's own depleted sense of self. We have reviewed ways in which the parent and infant can transmit anxiety or deflation to the other, restricting and impeding the partner's self-experience. Breaches of attunement and adjustment in the flow of interaction may compromise the holding situation, patterns of emotional referencing and a host of other potentiating frames of reciprocal experience.

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