Intimacy thwarted and established:

Following a girl from infancy to child psychotherapy

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Björn S: Introduction

A blood vessel's innermost layer is called *the intima*. Is intimacy then to reach the innermost of another being? Is it a "process by which a dyad – in the expression of thought, affect, and behaviour – attempts to move toward *complete communication* on all levels" (Hatfield, 1982, p. 271, italics added)? Klein (1975) states that this is a chimera: Indeed, "a satisfactory early relation to the mother… implies a close contact between the unconscious of the mother and of the child" (p. 301), but this does not imply a complete communication. Later in life, we love to "express thoughts and feelings to a congenial person, [but] there remains an *unsatisfied* longing for an understanding without words – ultimately for the earliest relation with the mother. This longing contributes to the sense of loneliness and derives from the depressive feeling of an irretrievable loss" (idem, italics added). Intimacy implies to unite in understanding and love – and to accept loss and loneliness. Without this combination, intimacy will be thwarted. We conceive of it as a *movement* and not a state, a *dance* and not a fusion. Like Klein, we suggest it builds up in infancy. What, then, if the dance of intimacy between mother and baby gets jagged and un-rhythmical? How would that alter the child's development of affection, understanding, and other abilities? As child analysts and researchers, we could study this question by following Annie and her mother from five months to 7½ years. Our presentation is thus a psychoanalytic "single case study" (Kächele, Schachter, & Thomä, 2009), in which the "variable is observed under various conditions" (p. 10), here, at four time points. Before presenting the case, we submit some general reflections on intimacy.

We are all fruits of intimacy as we are conceived – though far from always – in an act of love and hope. Once conception is accomplished, threats to the future parents' intimacy sneak into the marital bed. Seeds of jealousy, fears of responsibility, and the threat of losing the foetus mingle with shared joyous prospects. The anonymous inhabitant is thus destabilizing the internal worlds of the parents. They

need to uphold the equilibrium between narcissism and libidinal love, autonomy and dependence, love of life and fear of death. The expectant mother must also adjust her image of a body that behaves in mysterious, sometimes also painful and even precarious ways. The father's narcissistic equilibrium is also endangered but he may seek to deny this as long as the baby is "just inside her". Later, such self-deception will crumble when the baby screams through the night, breastfeeding doesn't work, and he must change the diapers.

The menace to intimacy is also posed by the awakening of infantile sexuality. During pregnancy, the mother's bodily alterations challenged her autonomy ("Who's running my life, me or 'it' inside me?") and sexuality ("What does 'it' do to my body and my passions?"). Then the newborn comes crawling on her body; sniffing, licking, sucking, peeping, and pooing. There is little room for adult sexuality, now that a tiny but insistent lover has appeared, and her partner has become a hollow-eyed guy googling at night-time on infant rashes. If intimacy is born in a close contact between the unconscious of mother and child, this implicates the infantile sexuality of both parties. Whereas "attuned secure parenting generates the interpersonal *context* for an erotically imaginative intercourse its *content* arises out of the adaptive mother – infant misattunement" (Fonagy, 2008, p. 26, italics added). Such misattunement arises because the sexualities of mother and baby, as Laplanche (1989, 1999, 2007) suggested, are veiled or enigmatic to themselves and to each other. In this relationship, messages easily become "opaque to its recipient and its transmitter alike" (Laplanche, 1995, p. 665). If it shall develop into intimacy the mother needs to interact with the infant with tolerance, humour, warmth, *and* a transparency (Bydlowski, 2001) to her unconscious infantile sexual fantasies.

This process can be jeopardized in postnatal depression; the fertile intersubjective gap in the misattunement between the sexualities of mother and baby can be widened into an insurmountable rift. These mothers are sometimes low-keyed or anxious about the baby's well-being. Narcissistic issues abound; they feel worthless, unable to love or feel intimate with the child. Guilt is ever-present. In interactions they tend to be disengaged or intrusive with the baby (Cohn & Tronick, 1989), who may protest or look away. Many studies confirm the link between maternal depression and infant behaviour problems (for reviews see Field, 2010; Grace & Sansom, 2003; Murray & Cooper, 1997; Tronick, 2007).

Postnatal depression has not received much specific attention from the psychoanalytic community (Blum, 2007). Thus the popular notion that it is "caused by hormones", as well as the psychiatric view

that it is “another edition of common depression”, have stayed undisputed. From our perspective it is more fruitful, both heuristically and therapeutically, to view it as an existential crisis. Few life events can unsettle more powerfully the everyday armistice between drive and defence than the arrival of a child. “Am I living for myself or for the baby? Am I my parent’s child or my child’s parent? What is important in life? What do I wish and not wish to transfer from my childhood to my baby?” One day, these questions are flung into the parents’ faces by the tiniest of prophets; the baby.

Nobody remains unshaken by the infant’s arrival. Some even get shattered and become, as does every sixth mother, depressed. Not so few of them intuit the existential dimension beneath their suffering. We would like to combine this observation with Winnicott’s (1956) concept of “primary maternal preoccupation”, “a very special psychiatric condition”, an “organized state” marked by a heightened sensitivity to the child and to herself. In such a destabilized state, an encounter with a psychoanalyst can be fruitful and vital. There are few times in life when a window into the interior is so easily opened up. Therefore, deep-reaching and rapid effects of therapeutic consultations are surprisingly common. We hope to inspire our colleagues to embark on such work.

To approach the congress theme, we have chosen a dyad from an RCT that later became a child therapy case. Our collateral aim is thus to show that quantitative studies can inform on therapeutic efficacy and visualize psychoanalytically relevant data. In other words, from the “extensive model” (Jacobs, Heim, & Chassan, 1966) used in a large sample study, one can extract single case studies based on the “intensive model” to fertilize psychoanalytic speculation and theorizing. Our observations during seven years indicate how dyadic interactions during infancy may become internalized in the child and, through therapy, be approached at a later stage.

The case

In my research interview with thirty-year-old Donna and her five-month-old daughter Annie, she began by stating, “I’m no good at this parent-child thing! I don’t like being off work, just rolling the pram. Guess I feel guilty. I know I’m not politically correct. It’s a new experience, being unable to compensate by working even harder! I didn’t feel well at the end of pregnancy. The doctor recommended a sick-leave. I told him I don’t have time. ‘That’s just your problem’, he replied. Delivery wouldn’t start so I had an emergency caesarean. The wound got infected, I was quite absent the first six weeks (laughs). That ‘immediate mother-baby-contact’ never appeared. The girl never liked breast-feeding, throwing herself backwards like an angry starfish. I fantasized throwing her out of the

window. Everybody is endorsing breast-feeding, but there's no scientific evidence that it's better than bottle-feeding! When my husband resumed his job I panicked. Being alone with the baby…"

Donna then claims that her *real* problem is that she cannot fulfil societal expectations about maternal happiness. She switches between transitory depressive realisations of an agonizing relationship with Annie and lengthier periods when she, in a more schizo-paranoid (Klein, 1946) mode, accuses society of extorting erroneous attitudes in mothers. Yet, she realizes "that at one phase in life one has to go through this thing about someone being totally dependent on you".

Donna's relationship with Annie is "functional. I'm the one who understands her needs". I ask, "how do you think Annie would respond if I asked her"? "I think she'd say Mum has too little patience, she is split and absent-minded." Then she caricatures the girl, "Mummy, I want attention ALL the time!" Only when I ask about her husband does she become tearful. She confirms her fondness of him and yearns for such emotions with Annie.

Donna has been ambivalent about motherhood since pregnancy started. Her love for Annie surfaces only with difficulty. Her negative feelings are more conspicuous. She detaches herself from the sensual aspects of motherhood and restricts it to a societal duty, which probably is an effort at ridding herself of guilt. When it becomes too weighty, she projects it onto society; it, not she, is rigid and overly demanding.

Annie is a child that was planned and longed for but pregnancy came as a shock to Donna. Her refusal to get on the sick-list reflects that "I'm a workaholic". If a mother, as Gentile (2007) puts it, needs to negate her own mind and offer the baby her "unimpinging subjectivity" (p. 556), this clashes with Donna's worldview. Like every mother (Harris, 1997) Donna is quite angry with her "occupant" but cannot integrate such feelings. Instead, she becomes annoyed and ironic with Annie.

Donna also speaks of her mother: "We've a very close and frequent contact… Well, I've an academic education but my parents haven't exactly read Strindberg… My Mum is hasty and doesn't think things through. I asked her if she thought anything special when she had me. She looked at me as if I was a Martian: 'Was I supposed to think anything special? I just did what I did'." Yet, Donna feels that Mum's

carefree attitude cheers up her own more sombre nature. I sense, however, that only briefly does her quick-witted and chatty language dip down into painful emotions.

Five months: first interview and video

The interview was part of an RCT launched in Stockholm. Eighty mother-infant dyads were assigned to either some 25 sessions with a psychoanalytic parent-infant therapist or to regular treatment at local Child Health Centres. In Scandinavia, this is an ambitious system with frequent check-ups with specialist nurses and paediatricians. They are also instructed to observe signs of postnatal depression and, if needed, suggest treatment. The study results (Salomonsson & Sandell, 2011a, b) favoured the analytic treatments on mother-reported depression (Cox, Holden, & Sagovsky, 1987) and stress (Östberg, Hagekull, & Wettergren, 1997), observer-rated dyadic relationships (ZERO-TO-THREE, 2005) and interactions (Biringen, Robinson, & Emde, 1998). The latter were captured from ten-minute videos. Let us now look at the recording at five months. My instruction to Donna was simply "be with Annie like at home".

Show video (4 minutes)

The video shows the mother's limited sensitivity. Her tempo is too fast for a baby. Facing the girl's mounting distress, Mum decides it must be "fart or poo-poo". I interpret this as one of many intrusive identifications, through which Donna seeks to depose unlovable and disgusting aspects of herself. Other such instances are her naming Annie "Plum-face" and asking, "Are you a Hawaiian who only knows vowels, ouayah?" The girl wants to be held in mother's arms, but she interprets this as appeals to sing or to change the diaper. The garrulous, up-tempo language that Donna used with me is also evident when she is with her baby. This leaves behind a doubt how she might contain the baby's distress.

In my countertransference, Annie seemed "aged" and concerned and her eyes looked sad. Now and then she was jumping up and down in Mum's lap. After the video-recording, Annie began crying and mother imitated her in an ironic way. As her screams intensified, so did mother's inability to soothe her. Meanwhile, Donna reported that breast-feeding had worked so-so until 2½ months, when Annie "refused the breast like crazy". Sleep was a constant issue, Annie was easily over-stimulated and could not be with her in a café. "All the time there has been something that doesn't work".

Eleven months: the second interview

Donna and Annie were randomized to Child Health Centre treatment. Six months later they came, according to the research design, for a second interview at eleven months. Donna said: "The filter between us is gone. The kind of transfer I have with my husband, I can have it with her, too. I've got some distance now so I've entered a positive spiral. I didn't understand I was depressed. I felt like shit. Now I'm a mother with a job, not a professional who happens to have a child."

Annie has just learnt to walk. She seeks contact and offers me a toy to play with ensemble. Donna says the girl suffered too during her depression, "but it didn't harm her. She still has problems with food, but now that she's not breastfeeding I don't take it personally. The sleep issues are gone. She is intense, curious, lively, has never been sitting still for long but that doesn't matter now that she can move around on her own."

On the video, mother's sensitivity has improved. As I leave the room when the recording starts, Annie looks after me and the mother captures this: "You got a bit sad as he left. Don't worry. He'll be back." Donna indicates and names various objects to the girl but does not notice when Annie is searching for her breast. She picks up a book to awaken the girl's curiosity but does not notice that she is uninterested. The tempo is still a bit up.

To summarize, Donna realizes that she was depressed in the beginning of Annie's life. Now she feels better and is grateful for her husband's support and also reports that his contact with Annie is better than hers. She enjoys more being a mother and has started dreaming of a second child. She tells herself that Annie suffered no harm but also reports food problems and a high level of activity.

Let us return to the topic of intimacy. If it implies to dance together, then it presupposes a sense of rhythm, an ability to listen and pick up signals from the other, and a love of oneself and the other. To what extent can intimacy mature when a mother doesn't like rolling the pram with her Plum-face baby and feels she has to go through "this thing" with someone being dependent on her? What if a baby bends backwards "like an angry starfish" at the breast, sleeps badly, and cannot be with Mum at a café? We suggest these initial observations indicate Donna's and Annie's problems with upholding an intimate relationship. Six months later, Mum's filter is gone, perhaps because her depression healed or Annie became more independent and her routines more established. But of course we

wondered if Donna was right that Annie had suffered no harm. As Majlis WS will now report, we got some answers a few years later.

Majlis WS: Four and a half years: the third interview

I met Annie for an interview when she was 4½ years old, as part of a follow-up of the RCT. The aim was to compare the long-term efficacy of the two treatments that Björn just referred. We chose an age when children can use words, participate in verbal tests, and be alone with me in an interview. Out of the 80 infants we now gathered data from 66 4½-year-olds, 33 from each group. Response rate was thus 83%. In the interviews I knew nothing about the children's history and assignment.

The video-recorded interviews started with our welcoming mother and child who then were separated into two adjacent rooms. Björn interviewed the mothers about their internal representations of the child (Zeanah, Benoit, & Barton, 1986). Meanwhile, I tested the child's cognitive functioning (Wechsler, 2005) and then gave a Lego toy and said: "You can assemble it with mother". Mother and child now reunited, played with the Lego and were later served cookies and lemonade. This sequence lasted 20 minutes and then they separated again. Björn now asked mother about health and life events since the infant study, and about her child's behavior and relationships at home and at pre-school. Meanwhile, I assessed the child's global functioning (Shaffer et al., 1983) and asked questions like "what do you do at home, at the pre-school, with your pals?" Mother and child then reunited and we said goodbye.

I assembled my impressions of the child into personally invented words. These so-called Ideal types (Wachholz & Stuhr, 1999) did not ascribe *numbers* to the levels of functioning but described every child in idiosyncratic *words*, such as "curious", "good girl", "a troublemaker", "scared", etc. In a second step, I distilled these words into four types: The *Open* child seemed lively, confident and open. The *Orderly* child was competent and kind, though somewhat moderate or inhibited. These two types were boiled down to the *OK* children. The *Anxious* child was worried, inhibited, or shy. The *Provocative* child was annoying, spiteful or overtly aggressive. These two formed the *Troubled* children.

The study results (Winberg Salomonsson, Sorjonen, & Salomonsson, 2015a, b) showed that children in the analysis group showed a better global functioning, and contained more "OK" children and fewer "Troubled" children. Also, the initial superior effects on depression questionnaires for the mothers in

analysis were maintained over the years. This probably gave them an advantage, compared with the group that did not receive analysis, when they handled and responded to their children.

Now to Annie: In the interview, she looked at me a bit tense and shy, and did not say a word. She left her mother without problems and focused on her tasks. She looked at me closely from time to time and then gave me a little smile. The tasks were solved quickly and easily. She looked pleased in a reserved way and then became more lively and relaxed: “Wow, this wasn’t that difficult at all”. When asked to make a drawing of a person, she made a witch (picture 1). It was making witch-soup with flies and mosquitoes. Suddenly she said she needed to make poo and added: “I can wipe myself”.

In the story completion test (Hodges, Steele, Hillman, Henderson, & Kaniuk, 2003) her stories often were about children who managed by themselves. Various dangers were denied, as in the story about a little pig lost in the forest. He managed to get home all by himself, nobody helped him, and all the wild animals around represented no danger at all.

In the video with mother and daughter, Annie was talking about me. Mother asked about me and commented Annie’s answers somewhat mockingly: “What did you talk about in there?”- What you need when it’s raining. ”What did you answer, a swimsuit?” (Mother laughed.) -No, I said rain hat and raincoat and rain boots. “Wouldn’t a swimsuit fit just as well?”

Donna reported to Björn that Annie disliked new situations unless informed exactly in advance. Playing by herself was difficult, and she wanted to control which games to play with her peers. Fear of losing face was another issue. She was fond of pre-school with its rules and routines. She had always been fussy with food. Mother added: ”Sometimes I wonder if she is still seeking that love I didn’t give her unreservedly that first year.”

My picture of Annie was of a gifted girl, restrained, inhibited and task-oriented. She seemed self-propelled and used an “I-can-handle-myself” defence against anxieties whose content I could, in this situation, only ponder about. I assessed her as an *Orderly* child and thus belonging to the *OK* group, though her global functioning was slightly beneath the clinical cutoff point. I also wondered about her long glances, as if on the slant, at me. In the countertransference, I got curious and warmly affected by

these looks. I understood my feelings further when I worked with my ratings of her general level of functioning. When I as usual discussed them with an independent expert, she claimed I sometimes rated Annie too high. I got hold of how I recognized myself in this diligent and task-oriented little girl. She seemed lonely and did not lean on other people when perils threatened. I was able to identify, through coming in contact with similar experiences in my childhood, with her pain of not being understood and of her loneliness.

In retrospect, I think Annie got interested in me since she sensed my empathy with her dilemma. This interest she played out in the video dialogue with mother about me. She tried to ward off mother's inquisitive questions, which increased when the girl repeatedly said, "I wanna go to Majlis again". Here we note an embryo of her positive transference onto me and, probably, the mother's negative transference as well.

Six years: the child psychotherapy

One and a half years later mother called. Donna described a chaotic situation at home. Annie often got temper tantrums and every family member, including her little brother 3½ years old, had to adapt to them. Annie had mentioned that she would like to meet "that lady". Eventually Donna understood that she was referring to me.

In my first interview with the parents, they added that Annie could not be alone *and* avoided physical contact. She was afraid of dogs and elevators and ground her teeth as well. But, she was also clever and well-behaved at pre-school. Tearful, mother recalled that she had always felt a distance between her and Annie: "In the beginning, I had no contact with her. It feels as if I've only had one pregnancy and one delivery", meaning the younger brother.

Some days later I met Annie, who smiled in shy recognition. She wanted to make drawings, a flower (picture 2) and a chair "to sit on" (picture 3). I thought this was her way of establishing a place for herself in my office. This marked the beginning of a therapy, in which I met Annie once a week for 1½ years and the parents once a month. Annie was eager to come and seldom missed a session.

Annie soon abandoned her courtesy and consideration. She became spiteful, cheated in games and wrote notes to me saying "Majlis is a shit, a fart sausage, a poo sausage". Here is a picture of me

(picture 4), in which everybody is laughing at me. I commented how hard it must be to be treated that way and feel so worthless. In response, she got even more contemptuous and mocked me as a weak loser. Rosenfeld (1971) describes a pathological organization of narcissism, by which the patient seeks to "withhold those parts of herself which want to depend on the analyst as a helpful person"(p.173). She despises these parts within herself as well as those parts in the analyst that are willing to provide help. Thus unconsciously, Annie reckoned that both of us were fart sausages. Her contempt and her attitude of self-management can be seen as developments of early defence strategies in answer to mother's way of handling her in infancy, and as an identification with comparable character traits in the mother.

In the countertransference, I felt a pull to both despise myself and seek revenge. This would correspond to Racker's (1968) concept of *complementary* identification. Here, "the patient treats the analyst as an internal (projected) object, and in consequence the analyst feels treated as such; that is, he identifies himself with this object" (p. 135). In short, I would have felt like shit. Yet, I managed to reach a *concordant* identification with Annie's underlying pain and contempt of her poo-self. I thus could stay in containment and reflection or, in Racker's words, reach an empathy "that really reflect[ed] and reproduce[d her] psychological contents" (idem). I told her it was not easy to feel left out and be afraid that the others could be mean and laugh. My identification with this denigrated child self helped me taste what it felt like to be Annie. And it hurt.

Annie's attacks on me slowly decreased. One day, she suggested we make a book together: "The tale of the perch who couldn't swim". She dictated, I wrote it down, and she made the drawings. Once upon a time there was a perch who couldn't swim. The other fishes teased him (picture 5). He slid down from the stone and got really sad (picture 6). Another fish asked "Do you want to play? – "But I can't swim so I cannot come and play. Can you teach me how to swim? – "Yes" (picture 7).

Annie pictures a fish, who is alone and abnormal since he can't swim. Then a helpful object is introduced, the swimming teacher. In the last drawing we recognize a formation like the chair returning from one of her first drawings. At that time, it merely indicated the hope of an upcoming frame to deal with her anxieties. This time the drawing is much more lively and spontaneous.

The roots of projective defence strategies in this mother-child couple could be seen already in the infant study. In the video, we saw how projective identifications took the shape of evacuations (Rosenfeld, 1987). If we recall Donna's comment "poo or fart, poo or fart" to the screaming baby, we see how a slipshod and nasty comment perhaps begins to be introjected as a bad internal object and then, in therapy, gets "exported"; first when Annie needs to make poo and then, secondly, onto me as a projection: "Majlis is a poo sausage". Due to patient containment, this traffic diminished and a depressive (in the Kleinian sense) mood came to the fore.

I had regular meetings with the parents, to share information and take care of Donna's fluctuating self-confidence as a mother. At the time of the perch story, the mother reported a major change in Annie and a deepening contact. At bedtime she burst into tears, saying she couldn't be nice to her family. Mother was surprised and thankful for this opening in their communication: "There are so many things going on in Annie's head that I had no idea of. She has always kept them to herself". Now Annie could open up and mother could receive and contain her daughter's self-contempt and fear of not being loved.

At the same time, our contact deepened. Annie became more open towards me, showed me her homework and ceased attacking me. Also, her sadness was more overtly displayed. She wondered what she could do so as not to destroy an upcoming family trip with her usual angry comments and outbursts.

After one and a half years of therapy. Annie wanted to end and spend more time with her playmates. "Earlier, I thought I was only angry and bad, but now I think that inside me there is somebody who sometimes is happy and sometimes sad." Her final words were: "Can I come back to you if I want to?"

Björn S: Concluding remarks

We suggested initially that intimacy is a "dance" in which two people develop a closer relationship while yet maintaining respect for the other's integrity. This ability, we added, is rooted in the interchange of mother and infant. If occasionally the two may imagine that they are blissfully united, in reality their interchange is constantly shifting between match and mismatch, as Tronick (2007) suggests in his Mutual Affect Regulation Model of Interaction. Applying another perspective, we suggest intimacy is one essential outcome of the Ps ↔ D dynamics (Bion, 1970), and that it is only achievable in moments of the depressive position. Sometimes one imagines being intimate, but this

may reveal to be an illusion built on idealizing projections onto the other and oneself. If such a discovery can initiate successful mourning, it may result in a respect of and an interest in the other. We believe this position paves the way for – or to express it even more clearly – it *is* true intimacy.

We then followed a dyad in which intimacy had been thwarted from the start. Pregnancy was wished for, but then considered a nuisance. A video and an interview at five months indicated several obstacles to intimacy. Donna's sensitivity was not optimal, her chatty language revealed a deficient contact with her emotions, and the projections onto Annie of bad characteristics were salient. Donna's relationship with *her* mother was factual, benevolent – and not intimate. This left her helpless and unable to discuss with her mother issues concerning Annie. The baby became a bright and diligent, but bossy and anxious latency girl.

We have portrayed a developmental trajectory, from the mother-infant interactions and the interviews, up through the child psychotherapy. One major question remains: How did the interactions we observed become internalized in the girl? Alternately, should we conceive of her symptoms in terms of instinctual conflicts, à la Klein? Indeed, we have conceived her internal world in terms of Klein and her followers, for example, by using terms like projective and intrusive identifications. Yet, Klein tended to downplay the external mother's impact on the baby and did not submit a solid theory of how mother and baby interact and influence each other's internal worlds. This led to a justified critique from Bowlby (1958) and others of the meagre empirical basis of psychoanalytic speculations about the infant's internal world – and to relevant attachment research. In our view, it also led to a thinning out of the focus on the unconscious internal world, and to the invention of a sometime laboured and novel metapsychology.

We suggest that no approach to understanding the child's inner world can be all-inclusive. Neither our observations of Donna's and Annie's interactions, the interviews, nor the child therapy can fully explain why Annie became an enraged, phobic, clever, and anxious latency girl. But we do claim to have enough empirical data for concluding the following: Donna's faltering containment, as observed in the videos and her ways of speaking about her baby, obstructed Annie's projections from being received and processed. Her emotions remained in an un-metabolized state and she became restless and fretful. Later, when seeking comfort, she met a mother who was less depressed and ambivalent but still cheery and guilt-ridden. Containment was now more helpful yet still not optimal. Despite conscientious efforts and good will, Donna could not heal the scars of infancy in Annie. Intimacy had

been thwarted in the cradle. It was, however, possible to establish it reasonably well through patient containment within a classical child psychotherapeutic setting.

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References

Bion, W. R. (1970). *Attention and interpretation*. London: Karnac Books.

Biringen, Z., Robinson, J. L., & Emde, R. N. (1998). *Emotional Availability Scales* (3rd ed.). Colorado State University: Unpublished manual.

Blum, L. D. (2007). Psychodynamics of postpartum depression. *Psychoanalytic Psychology, 24*, 45-62.

Bowlby, J. (1958). The nature of the child's tie to his mother. *International Journal of Psychoanalysis, 39*, 350-373.

Bydlowski, M. (2001). Le regard intérieur de la femme enceinte, transparence psychique et représentation de l'objet interne (The interior look of the pregnant woman, psychological transparency and representation of the internal object). *Devenir, 13*(2), 41-52.

Cohn, J. F., & Tronick, E. (1989). Specificity of infants' response to mothers' affective behavior. *Journal of the American Academy of Child & Adolescent Psychiatry, 28*(2), 242-248.

Cox, J., Holden, J., & Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry, 150*, 782-786.

Field, T. (2010). Postpartum depression effects on early interactions, parenting, and safety practices: A review. *Infant Behavior & Development, 33*(1), 1-6.

Fonagy, P. (2008). A genuinely developmental theory of sexual enjoyment and its implications for psychoanalytic technique. *Journal of the American Psychoanalytic Association, 56*(1), 11-36.

Gentile, J. (2007). Wrestling with matter: origins of intersubjectivity. *Psychoanalytic Quarterly, 76*, 547-582.

Grace, S. L., & Sansom, S. (2003). The effect of postpartum depression on the mother-infant relationship and child growth and development. . In D. E. Stewart, E. Robertson, C.-L. Dennis, Grace, S.L., & T. Wallington (Eds.), *Postpartum depression: Literature review of risk factors and interventions.* Toronto: University Health Network.

Harris, A. (1997). Aggression, envy, and ambition: Circulating tensions in women's psychic life. *Gender and Psychoanalysis, 2*, 291-325.

Hatfield, E. (1982). Passionate love, companionate love, and intimacy. In M. Fisher & G. Stricker (Eds.), *Intimacy* (pp. 267-292). New York: Plenum.

Hodges, J., Steele, M., Hillman, S., Henderson, K., & Kaniuk, J. (2003). Changes in attachment representations over the first year of adoptive placement: Narratives of maltreated children. *Clinical Child Psychology and Psychiatry, 8*(3), 1359–1045.

Jacobs, M., Heim, E., & Chassan, J. (1966). Intensive design in the study of differential therapeutic effects. *Comprehensive Psychiatry*, 7(4), 278-289.

Klein, M. (1946). Notes on some schizoid mechanisms. In R. Money-Kyrle (Ed.), *The writings of Melanie Klein* (Vol. 3, pp. 1-24). London: Hogarth Press.

Klein, M. (1975). *Envy and gratitude and other works 1946–1963*. London: The Hogarth Press and the Institute of Psycho-Analysis.

Kächele, H., Schachter, J., & Thomä, H. (2009). *From psychoanalytic narrative to empirical single case research*. New York: Routledge.
Laplanche, J. (1989). *New foundations for psychoanalysis [Nouveaux fondements pour la psychanalyse, 1987]* (D. Macey, Trans.). Oxford: Basil Blackwell.
Laplanche, J. (1995). Seduction, persecution, revelation. *International Journal of Psychoanalysis, 76*, 663-682.
Laplanche, J. (1999). *Essays on Otherness*. London: Routledge.
Laplanche, J. (2007). *Sexual. La sexualité élargie au sens Freudien ("Sexual". Sexuality enlarged in the Freudian sense)*. Paris: Presses Universitaires de France.
Murray, L., & Cooper, P. J. (1997). *Postpartum depression and child development*. New York, NY: Guilford Press.
Racker, H. (1968). *Transference and countertransference*. London: Karnac Books.
Rosenfeld, H. (1971). A clinical approach to the psychoanalytic theory of the life and death instincts: An investigation into the aggressive aspects of narcissism. *International Journal of Psychoanalysis, 52*, 169-178.
Rosenfeld, H. (1987). *Impasse and Interpretation: Therapeutic and anti-therapeutic factors in the psychoanalytic treatment of psychotic, borderline, and neurotic patients*. London: Tavistock.
Salomonsson, B., & Sandell, R. (2011a). A randomized controlled trial of mother-infant psychoanalytic treatment. 1. Outcomes on self-report questionnaires and external ratings. *Infant Mental Health Journal, 32*(2), 207-231.
Salomonsson, B., & Sandell, R. (2011b). A randomized controlled trial of mother-infant psychoanalytic treatment. 2. Predictive and moderating influences of quantitative treatment and patient factors. *Infant Mental Health Journal, 32*(3), 377-404.
Shaffer, D., Gould, M. S., Brasic, J., Ambrosini, P., Prudence, F., Bird, H., & Aluwahlia, S. (1983). A Children's Global Assessment Scale (CGAS). *Archives of General Psychiatry, 40*(11), 1228-1231.
Tronick, E. (2007). *The neurobehavioral and social-emotional development of infants and children*. New York City: W. W. Norton.
Wachholz, S., & Stuhr, U. (1999). The concept of ideal types in psychoanalytic follow-up research. *Psychotherapy Research, 9*(3), 327-341.
Wechsler, D. (2005). *WPPSI-III. Manual, del 1. Svensk version. (Original title: Wechsler preschool and primary scale of intelligence, 3rd ed.)* E. Tideman, Trans. Stockholm: Psykologiförlaget.
Winberg Salomonsson, M. W., Sorjonen, K., & Salomonsson, B. (2015a). A long-term follow-up of a randomized controlled trial of mother–infant psychoanalytic treatment: Outcomes on the children. *Infant Mental Health Journal, 36*(1), 12-29.
Winberg Salomonsson, M., Sorjonen, K., & Salomonsson, B. (2015b). A long-term follow-up study of a randomized controlled trial of mother-infant psychoanalytic treatment: Outcomes on mothers and interactions. *Infant Mental Health Journal, 36*(6), 542-555.
Winnicott, D. W. (1956). Primary maternal preoccupation *Through paediatrics to psycho-analysis* (pp. 300-305). London (1982): Hogarth Press.
Zeanah, C., Benoit, D., & Barton, M. (1986). Working model of the child interview. *Unpublished interview. New Orleans: Tulane University*.
ZERO-TO-THREE. (2005). *Diagnostic classification of mental health and developmental disorders of infancy and early childhood (DC 0–3:R)*. Washington: DC: ZERO TO THREE Press.
Östberg, M., Hagekull, B., & Wettergren, S. (1997). A measure of parental stress in mothers with small children: dimensionality, stability and validity. *Scandinavian Journal of Psychology, 38*(3), 199-208.