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Agnieszka Kałwa

THE SPECTER OF ASPERGER'S SYNDROME IN PARENT-INFANT PSYCHOTHERAPY. A CASE REPORT. [1]

Mazovian Neuropsychiatric Center

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Summary

Psychoanalytic Parent–Infant Psychotherapy (PIP) has recently been offered in Poland. It is based on psychoanalytic theories but also uses data from current scientific research. The article is a psychodynamic conceptualization of the PIP psychotherapy process. The therapist's hypotheses regarding the conscious and unconscious components of the relationship between parents and infant and the problems occurring therein play an important role. On their basis, therapeutic goals are formulated and methods that can be used as part of therapeutic intervention are selected. Therapeutic hypotheses include countertransference, observations and interpretations of the therapist. The article describes the process of PIP psychotherapy for an infant and his parents, which included 40 sessions. It started when the child was 5 weeks old and ended when he was 17 months old. From the beginning, the issue of diagnosing Asperger's syndrome was an important topic. Although, according to the parents, this diagnosis could have been stated for the child in the future, it already played an important role in the child's life when the therapy began. This work describes what happened to the specter of Asperger's syndrome in the family described above, during the process of PIP therapy.

Introduction – diagnosis of Asperger's Syndrome and its importance in this work

A specter is a spirit, apparition, immaterial being, or the illusion of such a being. It appears unexpectedly and disappears just as unexpectedly. Combining this word with the concept of Asperger's syndrome may seem contradictory. Asperger's syndrome is a neurodevelopmental disorder related to the atypical development and functioning of the central nervous system. In the ICD-10 classification in force in Europe [1], it belongs to pervasive developmental disorders, which include, among others: autism and its milder form – Asperger's syndrome. The neuroatypical nature of people with this disorder results in certain differences in functioning compared to "typical" people. It manifests itself in:

[1] This work was created thanks to the possibility to conduct outpatient parent-infant psychotherapy at the Mazovian Neuropsychiatric Center and as part of the collaboration with the Polish Association for Infant Mental Health.

1. Qualitative changes in mutual social interactions: difficulties in reacting to other people's feelings, difficulties in modulating behavior depending on the social context, weaker integration of social, emotional and communicative aspects of behavior.
2. Qualitative communication disorders: problems in the social use of language skills, engaging in games based on imagination and social imitation, synchronization and reciprocity in verbal dialogue, poor variability of language expression.
3. Restricted, stereotypical patterns of behavior, interests and activities, compulsive or ritual activities such as stereotypies, schematic behavior, rigid adherence to the established order, resistance to change.

The present article describes the challenges associated with the issue of Asperger's syndrome in Parent-Infant Psychotherapy (PIP). Pervasive developmental disorders are rarely diagnosed in infants. In the presented case, the youngest therapy participant did not have such a diagnosis. Nevertheless, already at the beginning of therapy it played an important role in his life.

What is psychoanalytic Parent-Infant Psychotherapy (PIP)?

The relationship with early caregivers is very important, influencing the child's development at the emotional, physiological and neural levels. It shapes patterns of attachment that remain present throughout a person's life, influencing how he or she enters into close relationships with others. Disruptions in the relationship with the closest caregivers may result in problems in the child's development already in the first months of his or her life. The infant does not know words yet, but reacts emotionally, can send signals to the closest caregivers and is particularly sensitive to their reactions. Research related to the micro-analysis of face-to-face communication between infants and their mothers [2, 3] indicates that in four-month-old children it is possible to predict a pattern of attachment and interaction with the parents. Contemporary PIP psychotherapy uses the above results of scientific research, shaping in therapists not only the ability to carefully observe current interactions between the infant and his parents, but also emphasizing interventions concerning primarily what is happening between all individuals present in the therapy room.

PIP psychotherapy has recently been offered in Poland. It starts in the child's infancy (0-12 months). PIP sessions take place simultaneously with the participation of the therapist, the child and its mother or both parents. The method of conducting therapy ensures the child's empowerment, during the intervention the therapist addresses verbally not only the parents but also the child. At the same time, the therapist remains sensitive to all non-verbal signals, including information from the own body and the emotions felt. The environment where psychotherapy takes place should be adjusted to the child's needs – usually it is a specially adapted room where adults sit on the carpet and the child has the opportunity to move freely and move around at his own rhythm, in a manner appropriate to the current developmental possibilities.

In the parent-infant relationship, it is relevant how the child appears in the parents' mind. The representations of the mother's and father's worlds are not only a collection of their past experiences, but they also unconsciously concern their emotions, ideas, and expectations towards the child [4]. PIP applies analytical thought to capture the affective experience and representation of parent and child in their relationship. This ensures that the adult's attentive mind responds to the child's needs, which ensures the child's best development and attachment.

Maternal preoccupation, maternal failure and maternal ambivalence

PIP refers to analytical concepts that have been formulated in relation to the infant's relationship with the mother. Nevertheless, nowadays it is also increasingly using knowledge about the child's relationship with its father, which has been underestimated for years, and which is increasingly appearing as a topic of current research [5]. Important concepts are *primary maternal preoccupation* and *maternal reverie*. Maternal reverie, formulated by Bion [6, 7], describes the mother's state of mind, beginning in late pregnancy, when the infant is already in the center of the mother's emotional involvement [8]. This is an unconscious process that allows the mother to accept the specific needs of the infant, who is defenseless and completely dependent on caregivers. It allows the mother to imagine her infant's emotional and bodily experience and give it meaning in such a way that provides holding in the mother's mind. Maternal failure means the inability to accommodate an infant through maternal care. This is an intrapsychic process within the mother that may manifest itself in projections projected onto the child. As a result, the mother sees in the infant someone completely different than who the child actually is. Usually, these are closest relatives from her own difficult past. This disturbs the process of "ongoing being" in the infant, threatening to destroy the infant's self [7, 9]. In turn, Winnicott [7, 10] introduced the concept of *maternal ambivalence*, seeing it as moments of hatred accompanying mother's love, understood as an inevitable phenomenon, present in the situation of a very specific period of the mother's life, in which the appearance of an infant introduces a unique routine and limitations. At the same time, the mother is being sensitized to her experiences from her own infant period of life. Awareness of ambivalence means that the mother is able to tolerate negative feelings towards the child. However, when emotions related to maternal hatred are denied or repressed, maternal ambivalence may increase in a way that is undesirable for the mother-baby relationship.

This work presents a psychodynamic formulation of parent-infant therapy. The therapist's hypotheses refer to the conscious and unconscious components of the relationship between parent and infant, as well as to the problems occurring in it, which play an important role. This influences on how therapeutic goals are formulated and which methods may be used for therapeutic intervention. Therapeutic hypotheses are constantly verified during therapy – questioned and modified, clarified and developed as the therapeutic process progresses. They include countertransference, observations and interpretations of the therapist.

Application for therapy

Mr. and Mrs. A. applied for outpatient PIP psychotherapy offered under the National Health Fund, with their 5-week-old son – the fourth and youngest in the family. They were referred by a psychiatrist who worked in the same institution and took care of their older 14-year-old son, who was treated in a day psychiatric ward and was diagnosed with Asperger's syndrome (AS). This diagnosis was also given to their oldest 16-year-old son, who in the past also used to be treated in the same psychiatric outpatient ward. Mr. and Mrs. A. also had a 2-year-old son who had not yet received a diagnosis, but in their opinion he was already exhibiting behaviors specific to AS, which in the past had been manifested in the first years of life of the older children. Mr. and Mrs. A. unanimously believed that the father of the children also had AS features, and although he had never been diagnosed, he recognized a specific style of social functioning in himself. He reported that his current way of understanding and creating relationships with people required effort from him. The difficulties of his children were understandable to him, he felt similar to them in a way. The older sons were diagnosed with AS only in their teenage years, although from the perspective of their parents, especially their mother, from an early age they manifested difficulties in their functioning, the overcoming of which was a great challenge and burden. Additionally, for the first time in the family, the diagnosis of AS was stated in occurrence of a serious crisis related to the health of the eldest son, with a threat to his life and health. For the parents, especially for the father, it was important to know that parent-infant psychotherapy uses knowledge based on scientific research. He perceived it as a "new scientific program" that would provide an opportunity to prevent problems in infants as early as possible. The parents wanted to give their youngest child everything that was best to protect him from the difficulties resulting from AS.

The family was complete, they lived together. Mr. A. worked professionally and supported the entire family. He was treated pharmacologically for depression and recently underwent his own psychotherapy. Due to the need to take care of her youngest child, Mrs. A. stopped working as a self-employed person and has not yet been provided with individual psychotherapeutic care, although she often talked about such a need during meetings.

Relationships between mother, father and infant

Mrs. A. felt very burdened and tired. When the therapy started, she was still in the postpartum period (5 weeks after giving birth). Her physical condition was not good and required rehabilitation, which was impossible for her to organize while taking care of the infant and the other three very demanding children. She often pointed out that before her older children were diagnosed with AS, she had often wondered why she could not enjoy life like other mothers who could combine motherhood with professional work and taking care of their own needs more easily and freely. Mr. and Mrs. A. did not have the opportunity to use their own parents' help in raising their children, due to their chronic diseases and occasional deterioration of health, periodically requiring hospitalization, as well as

the distance that separated them. During PIP therapy, Mrs. A.'s physical condition slowly improved. However, she was still tired from the many tasks and additional burdens she was taking on. In this situation, it was difficult for her to prioritize the needs of her youngest child. The prospect of raising another child with AS also seemed very burdensome. She felt frustrated because of her desire to return to work, which seemed unrealistic in her current situation. During the sessions, Mrs. A. had a great need to talk about her own burdens, touching on many topics. In such moments, very often, although she held the baby close to her body, she was turned away from his face. However, she remained very sensitive to the child's strong cues, especially those indicating impending danger (e.g., a fall). She responded to every cry of her son immediately, hugging and comforting him. One of the methods of comforting the child was breastfeeding, to which the boy responded with noticeable relief, although later in the therapy he was able to bite his mother's breast at moments of tension.

During the first sessions, the baby often slept in a car seat, from which the parents did not take him out so that he would not wake up. At the beginning of therapy, they perceived the boy as a calm, "problem-free" child. The topic that aroused emotions was the issue of a possible diagnosis of Asperger's syndrome, which seemed to obscure their curiosity about the child. Mr. and Mrs. A.'s son seemed invisible given the magnitude of this possible diagnosis. Both parents denied the stress the child might be feeling. They noticed negative feelings only in children who had mastered the ability to speak and were able to inform their parents about their emotional state using words.

Throughout the entire therapy period, the boy tried to be close to his mother, often even clinging to her. He reacted with very loud protest and crying when she moved away from him. He could also cry and scream very violently in response to other undesirable situations, e.g., dressing him in warm clothes before leaving the therapy room. Even in his early infancy he seemed interested in contact with people. As he developed, he gradually became more willing to establish relationships – he smiled and responded very clearly to the therapist's reactions. However, he did it from a distance, remaining very close to his mother. When he was older, especially when both parents were nearby, he sometimes stopped responding to the therapist, avoiding her and not looking at her. When during the session the adults stopped paying attention to his signals, he turned to his mirror image, reacting positively to it, smiling and kissing it. Gradually, as his age increased, he showed more and more frustration and determination. During the sessions, the boy was reluctant to let go of the toys, even if he was interested in several of them, which made it difficult to play freely. His parents believed that this was because his older (over 2-year-old) brother was competing with him at home and taking away his toys. On the other hand, this situation could be interpreted as an attempt by the child to maintain and protect what is important to him, and at any moment could disappear, becoming beyond reach.

Mr. A. showed a lot of enthusiasm and joy in contact with his son, who reacted with spontaneous joy and loud laughter. However, often, especially during the first meetings, the father was quickly becoming disconnected. He often closed his eyes while sitting comfortably against the pillows. Replying to his wife's comments, he would say that he

was not sleeping and was listening carefully to everything. He reacted similarly to comments about looking at his cell phone. Sometimes he said directly that he felt unnecessary in such an intense conversation between his wife and the therapist.

Both spouses talked about existing communication problems and a feeling of mutual misunderstanding and underappreciation. This was observed during the sessions. When the mother raised many topics, the father reacted with withdrawal. When the father wanted to say something, he needed to do it in a comprehensive and logical manner. It required a strong commitment from the interlocutor, a lot of time and words. Mrs. A. was often unable to bear it. One of the problems in the relationship with her husband was the injustice in the division of household chores. Mrs. A. felt excessively burdened not only with the responsibilities of running the house but also with the "logistics" associated with trying to meet the needs of all the children. At the same time, it was difficult for her to let her husband "do something his own way" and not according to her guidelines. She called herself the "house general."

Mr. and Mrs. A. showed some ambivalence towards the diagnosis of Asperger's syndrome. They often talked about the specific features of Mr. A. and the older children in a warm and humorous way. Mr. A. perceived neuroatypicality as a resource that may be associated with original or even better functioning in certain areas compared to most people. In moments of anger at her husband, Mrs. A. more clearly referred to him as someone who "passed on the AS gene" to her children. She indicated that Mr. A., striving to fulfill his dream of a large family, inspired her to give birth to another child, which she no longer had the strength and resources to raise.

Unconscious internal conflicts that triggered defense mechanisms in individual patients and patterns of coping with them

Mrs. A. wanted to be a good mother who had time for her children and at the same time took care of herself. However, she could not accomplish this because her children required special care and attention. She was unable to meet all their needs, which resulted in a strong sense of guilt. At times she regretted her decision to be a mother. There was no doubt that she loved all the children and cared about them very much. At the same time, she sometimes avoided closeness to them. She did not like playing with them. Sometimes she was unable to hug her older children. The arrival of her baby aroused her own strong needs for being cared for and protected. Although Mrs. A. was the only child of her parents, in the past no one cared about her as much as she cared about her own children. Mrs. A. talked about having little insight into what was happening to her emotionally. She was aware that she often "cuts herself off" emotionally from what is happening around her. Isolating her feelings was a defense mechanism that allowed her to accomplish multiple tasks and endure it mentally. Unconsciously used defense mechanisms were related to projection. She perceived her husband as rejecting her and "infecting" the family. She tended to transfer difficult emotions of fear and anger onto him, which she tried to repress in relation to the children. Mrs. A. loved her youngest son very much and she desperately tried to help

him. For most of the duration of PIP therapy, she denied feeling any negative emotions towards him. However, as the child developed, she increasingly began to perceive him as someone who negatively assessed her actions. Not only does it painfully indicate that the mother is experiencing another failure, but at times he intentionally exceeds her limits in order to lead her to this failure.

The child, who stopped being an infant during the therapy, still clung to his mother, fearing that he would lose her emotionally, being very sensitive to her "disappearance" in situations when she was absorbed in many matters. The fear of emotional loss of parents also appeared in the event of their conflicts and mutual accusations. When the closest caregiver could emotionally disappear at any moment, the child experienced a sense of chaos. Feeling too much tension, the baby was starting to cry or, occasionally, was hitting his head against the wall or objects around him.

Mr. A. wanted to be present in the lives of his children, including the youngest ones, whom he very much wanted to bring into the world. At the same time, he himself needed care, structure, and emotional warmth. He often soothed himself by hugging the children. He was in a difficult situation because by bringing more children into the world, he wanted to get closer to his wife, not distance himself from her. He reported that raising children was only a transitional stage (in a sense "cancelling" the current difficulties), after which his wife would remain with him. He spoke about Asperger's syndrome with humor and warmth, also in relation to himself. He rationalized and intellectualized a lot. At the same time, he defended himself against the unconscious fear that he had brought misfortune to the family in the form of further illnesses and burdens. He seemed to be more sensitive to his own emotions than his wife. When the defense mechanisms related to repression failed, he would fall into the overwhelming depressive feelings connected with helplessness.

Patients' resources and engagement

The family had many resources. Despite life and financial challenges, the situation remained stable. The parents were educated people, and the oldest children showed special intellectual and musical abilities. Both parents loved their children, they seemed to be very present in their minds. The parents cared for them as best they could. They relied on their previous experience of being parents of young children in the past when their older sons were that age. They remembered what a crisis that time was for them and how they managed to get through it. Despite marital conflicts, there was emotional warmth in the family. The family's resource was a sense of humor, which at times seemed specific in the parent's friendly attitude towards the symptoms of Asperger's syndrome, which characterized the males in the family. The parents' account also showed that the older sons are affectionate towards their younger brothers and willingly participate in shared family moments.

A very important resource possessed by the youngest patient was willingness to form relationships and responsiveness in interactions with other people. A resource that was revealed in the therapy room was also the child's opportunity to experience his own space in contact with the parents, without the physical presence of the siblings.

There was ambivalence on the part of the parents regarding the motivation for therapy. They wanted to attend the sessions but withdrew from them due to their own burdens. During psychotherapy, they also experienced their children's illnesses. The most difficult period was the sudden life-threatening condition of the infant suffering from bronchitis, which the mother managed to control with the help of her eldest son. The mother was the person most involved in the meetings, she participated in all of them, including those in which other participants could not participate fully (sleeping child) or at all (husband's absence). Sometimes she canceled sessions, openly saying that she was able to come but decided that other, more important matters would come first. The family had trouble starting sessions at the scheduled time. During the therapy, sessions were also canceled by the therapist due to her illness or vacation. Although this did not happen often, it had an impact on the therapeutic setting.

Therapist's countertransference reactions

The therapist expressed a lot of warm feelings towards the entire family. She had a need to care for everyone who needed taking care of and for whom she could be important and needed. At times she felt angry due to frequent lateness, missed sessions, and the father's absence; although at the same time, she tried to understand the burdens of the family, sympathized with the parents in difficult situations related to fear for the health of both their children and their parents. She felt anxious when information appeared about the deterioration of the youngest patient's health. Raising difficult, painful topics was made difficult by the feeling of guilt expressed mainly towards the child's mother for "violating" her, causing her distress, and towards both parents for making them look like "bad parents". The child aroused curiosity, joy and tenderness when he smiled at the therapist. However, in moments of withdrawing from contact and stopping looking at her, sadness appeared.

Therapist's hypotheses

All the above stages of conceptualization led to the formulation of the following hypotheses verified during the therapy:

1. Parents unconsciously fear that they are a threat to their children and feel guilty because of this. This fear takes away space for the child who cannot be fully seen. Parents do not want to see this and engage in mutual conflict.
2. Mrs. A.'s maternal ambivalence increases when moments of difficult emotions towards the child appear, which she does not accept.
3. In the case of discussing the above topics related to fear and ambivalence, parents react in different ways of withdrawing from the conversation about the most painful emotions – e.g., the mother reacts to it by excessive talking, at some moments the parents argue and lose focus on the child. They also react passively – they do not arrive at the sessions explaining that they had other priorities, they forget about them, they are late.

4. The child tries to "break through" to his parents, feeling afraid that he may lose them emotionally at any time. When they do not respond to his efforts, he feels chaos.

Goals of therapy

The initial goal of therapy was discussed with the parents, although establishing it was challenging. The parents were not sure what type of help they could count on, and during psychotherapy they returned to the concept of a "new scientific program" and asked whether psychological diagnosis of the child would be part of the care. However, from the beginning of PIP psychotherapy, they agreed that they wanted to provide the child with the best possible prevention in the event of the possible development of Asperger's syndrome. Later in the therapy, they identified, as one of the important goals, minimizing the impact of their mutual conflict and the resulting tension on the child.

From the therapist's perspective, the goals were formulated in a way that was compatible with the hypotheses presented above and verified during the meetings. They were as follows:

1. Helping the parents to see their child's needs beyond the consideration of a possible future diagnosis of Asperger's syndrome and mutual conflict.
2. Helping the child to be "visible", in the foreground and emotionally accepted by adults just as he is.
3. Reducing maternal ambivalence. Raising and deepening the topics of emerging negative feelings of the mother towards her child. At the same time, increasing the sense of pleasure of being with the baby.

A form of therapeutic interventions

Setting priorities was a constant challenge in the process of psychotherapy for A.'s family. It involved creating space for therapy when parents had limitations, for example, organizing online meetings when no one could come to the session. Whenever possible, in exceptional situations, the therapist proposed "substitute" meeting dates. One of the parent prioritization interventions was to draw their attention, as empathetically as possible, to lateness resulting in less time for the child. It was also important to establish a plan for ending the therapy.

A common form of intervention during PIP sessions was stopping the parents. The therapist tried to limit the mother's tendency to address multiple topics and direct her attention to deepening the topics. During sessions with both parents, the therapist tried to increase the father's presence in the conversations. Stopping interventions were also targeted at both parents in order to direct their attention to the child's reactions, acting as a mirror for them of what was happening in their relationship with the child in the room. The breakthrough session was a meeting during which the parents realized how their child felt when they could not see him, as they were experiencing strong emotions related to directing various accusations at each other. The therapist described step by step to the parents what the child

was doing, who he approached and how, and how he reacted when neither of the parents responded to his cues. This meeting was a very intense and shocking emotional experience for them. At the same time, they were able to express gratitude for this experience and for what they had gained from it.

The therapist's way of working, mainly during sessions in which the mother and the baby were present, also involved modeling forms of contact with the child. The therapist positively drew attention to the face-to-face contact between the mother and child. She supported the mother in playing with her child, sometimes modeled the way of playing, and tried to notice and strengthen all manifestations of joy in mutual activity. Therapeutic interventions were aimed at experiencing greater pleasure from contact with the child.

An important element of the therapy was working with maternal ambivalence – reaching the negative feelings towards the youngest child, pausing on painful, difficult-to-accept topics and deepening them. Difficult, internally denied "taboo topics" could only begin to appear when the child's mother gained space to talk about her needs and feelings in a way that allowed her to deepen one painful topic, giving up many superficially discussed topics, while keeping the youngest child in her mind.

End of therapy

Parent-infant psychotherapy for A.'s family took 40 sessions. The child was 5 weeks old when it started and 17 months old when it ended. In a way, the time of ending PIP is determined by the age of the child, who is no longer an infant and enters a new developmental stage. All individuals present at the session can feel it. A room specially adapted for parent-infant therapy is no longer "sufficient" for an older child who has an increasing need to explore the surroundings. In the case of A.'s family, determining the end of therapy became a challenge. At this stage, the setting of the meetings was once again disturbed. Parents canceled subsequent meetings for various reasons, which seemed to "prolong the separation." At the same time, taking into account the developmentally appropriate needs of the child (active, exploring), an online meeting seemed unlikely to be possible. In turn, the therapist, although she had been discussing the issue of ending the therapy with the family for three months, "did not manage" to set a specific date for ending the meetings. However, when the date was set, two meetings were held to end the therapy with all participants.

During the therapy, many changes took place in the life of A's family. The child reached a new stage of development. At the end of the therapeutic meetings, the boy started attending a nursery, where the adaptation process was slow but peaceful. The parents showed great care to ensure that the changes in the child's life related to separation and transition to the new environment were not too sudden. The child came to the nursery on specific days, for a short time. His mother accompanied him during his first meetings. Before that happened, a babysitter began to appear at the house. She was a neighbor previously known to the children, at the retirement age that was closer to a grandmother, whose care they could not experience on a daily basis. This gave the mother space to deal with important matters, including those important to her health. The mother's increasingly better ability

to "let go" of taking on additional burdens, rest and take care of the needs of her youngest child was noticeable. Mrs. A. experienced more and more moments in which she felt positive emotions when she saw her child's joy when he was having fun. At times she felt pleasure in playing together. Mr. A., in order to be able to spend more time with the youngest children every day, reorganized his work schedule in such a way that he came home earlier, although this meant getting up for work very early in the morning. The most important achievement in PIP therapy from the parents' perspective was that they learned to better understand their child and recognize its needs. The youngest son seemed to be more "visible" in his parents' mind. He no longer appeared as a "problem-free, always happy" child. He became a boy who emphasized his needs, stood up to his older brother, made decisive decisions that were not always pleasant for the parents and sometimes required setting boundaries for the child. At the same time, the parents seemed proud of his achievements and enjoyed these moments with their child.

At the end of the therapy, the specter of Asperger's syndrome appeared very faint. The parents had less need to raise this topic and spoke about it with less tension. At this time, their almost 3-year-old son was psychologically diagnosed with features of Asperger's syndrome. In relation to the youngest child, the parents were able to calmly accept what time would bring, without excessive fear that they should currently notice something in the child that would require intervention. Throughout the entire therapy period, the parents shaped a positive image of Asperger's syndrome as characterizing the family and giving it special features. Sometimes it resembled "laughter through tears" and involved activating the sense of humor, allowing these features to be shown in an honest, revealing and at the same time warm and sensitive way. The diagnosis, which on the one hand was associated with fear and burden, on the other hand seemed to unite the entire family, giving it unique opportunities.

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Email address: agnieszka.kalwa@centrumzagorze.pl