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Affective communication of infants with autistic spectrum disorder and internal representation of their mothers

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Abstract We have been examining the developmental process of affective communication in infants with autistic spectrum disorders from the viewpoint of relationship disturbance through our developmental and psychopathological studies on autism. In particular, the role of internal representation of the mother in the process of development of affective communication is discussed through the presentation of two cases diagnosed as autistic spectrum disorder in early infancy. In these cases, we postulate approach-avoidance motivational conflict as the primary factor impeding development of affective communication, focusing therapeutic intervention on this perspective. As a result, attachment behavior was remarkably improved in the children, but affective communication with their mothers was not readily improved. Taking up the mothers' own internal representation in mother–infant psychotherapy, in particular, the mothers' problems in attachment behavior with their own mothers in infancy precipitated transition in the mothers' internal representation of their children, leading to active evolution in mother–child interaction and development in affective communication between mother and child. In this context, the basis and significance of internal representation of both parties being determinants in the quality of mother–child communication are discussed.

Key words affective communication, approach-avoidance motivational conflict, autistic spectrum disorder, internal representation, relationship disturbance.

INTRODUCTION

In the early years, Kanner captured the principal problem in autism as being autistic disturbance of affective contact.[1] However, through autism research in the intervening years, the disorder has come to be viewed as a disability based upon cerebral dysfunction affecting the individual, such as that represented by the language cognition disturbance theory, with the psychosocial factors being relegated to virtual neglect as being issues of secondary importance.

However, long-term follow-up studies on autism have now revealed that social disturbances remain strongly evident even after improvement of the language cognition aspect, indicating that the association between language cognition and development of sociability is not as simple as was believed. As such, autism research has entered a new stage, with the trend being to re-evaluate Kanner's original assertions.[2] Today, debate is once again active surrounding the relationship between disturbance in language cognition and socio-emotional disturbances given the findings from the biological studies in recent years.[3–6]

We have been evaluating treatment strategies for autism from the standpoint of developmental psychopathology aiming primarily at cases of adolescent and adult autism. Through such analyses, it has been demonstrated that within the psychopathological framework of autism, there exists a characteristic primordial perception mode unaffected by aging, namely, physiognomic perception[7] and vitality affect,[8] which are readily activated in autistics much in the way as they are in infants.

In speaking of communication, it is commonly understood as a structure for mutual exchange of

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concepts. However, the structure of communication is characterized by duality in that in primordial form, it also represents the existence of mutual sharing of emotion at its foundation.[9] It is considered that physiognomic perception[10] and vitality affect,[11] which are characteristic modes of perception in the infant, undertake vital roles in the establishment of mutual sharing of emotion between the mother and child.[12] The fact that these modes of perception can also be noted in autistics indicates the possibility that such subjects possess the basic ability for establishing affective communication with others.

However, because autistics exhibit abnormal hypersensitivity to external stimuli,[13,14] their tendency for evading interpersonal interaction is markedly pronounced,[15] and the resulting breakdown in affective communication is believed to be the primary issue requiring resolution in the therapy of autism.

Affective communication between mother and child is something which can only be established given good affect attunement between the two,[11] which allows for mutual sharing and unfolding of emotion. Hence, should this attunement be readily disrupted, subjects would be incapable of applying meaning to their ever-changing environmental world, transforming the environmental world into a chaotic and fearful entity for them. Kobayashi has conceptualized this characteristic state of perception as the 'perception metamorphosis phenomenon'.[16]

These findings indicate that the perception mode of autistics is akin to that of infants, and that the great difficulty they face in applying meaning through the auspices of language as the function whereby they can share their perception of the environmental world with others is the fundamental issue in their commonly recognized language cognition disturbance.[17] Working upon this understanding, Kobayashi has studied the mechanisms whereby these perception modes develop into the various pathological states seen in autism.[18]

For these reasons, we focused on affective communication, as the mode whereby development in communication between autistics and their caregivers is achieved, believing in the importance of setting improvement in that area as the first goal in therapy. This reasoning stemmed from none other than recapturing the psychopathology of the autistic character in autism as disturbances in both sociability and development of communication, which led to the need to re-evaluate the developmental process of communication itself.

In this study, two cases of autistic spectrum disorder in early infancy are presented for detailed evaluation of the mode of development of affective communication in such subjects. In particular, focus is turned upon the role of internal representation on the part of the caregiver in the process of establishment of affective communication.

CASE PRESENTATION

Case 1: Subject 'T', male (1 year 8 months at first visit).

Chief complaint: Delay in language, minimal attachment to parents.

Developmental history

The death of the maternal grandmother 2 months before T's birth and the grandfather, living separately following divorce, being hospitalized at the time for pneumonia, were events that placed a large demand on the mother's time.

Both gestational and perinatal periods were normal. First steps were taken at 11 months. People-shyness and inseparability from the mother were non-existent. The child was perceived as an easy, undemanding child up to 18 months. At the time, it was pointed out that he was autistic at a health check-up for 18 month olds. The parents were concerned and read all types of child rearing manuals before visiting our clinic. Recent behavior which struck the parents as troublesome included delay in language, minimal interest in all matters, played with certain toys only, immersion in solitary play and temper tantrums when disturbed, and obsession with TV, so much so that his attention would stray to the screen even when someone was playing with him. For these reasons, they attempted keeping him company all the time, as was recommended in a book. The attempt was discontinued after 3 days, as it resulted in escalated night crying. The parents said that they were aware of many other types of worrisome behavior, such as thinking nothing of going long distances on his own, rarely returning one's gaze, stereotypic behavior such as tiptoeing or making his hands flutter, and waking up suddenly in the middle of the night showing great fear.

Reflecting on how they had been dealing with their child up to then, the parents vowed to become involved with T as much as possible. They said that it was making a great difference for the better. The mother said T was starting to show signs of affection towards her, and that the incidence of babbling was increasing. Imitation had also shown great increase, although clearly meaningful words were as yet unrecognized.

State at first visit

T appeared to take some notice of the author's presence and would occasionally meet his gaze, but basically played alone, showing no people-shyness or wariness. The play was stereotypic, and once he settled on spinning a chair around, he continued to do so with mute insistence. Utterance of words was noted, but with remnant echolalia.

Notable characteristics were that T had been an easy, undemanding child until recently, there was poverty of spontaneous or active behavior, restlessness and little display of affection or attachment behavior toward the mother, and he acted mostly at his own pace. Of particular note was that T would at times approach his mother indicating his wish for interaction, but the mother, unable to sense the child's feelings, would act upon the child driven by her own anxieties which would result in T avoiding the mother's approach.

Diagnosis at first visit and therapeutic policy

The case was believed to be one of autistic spectrum disorder,[19] given the behavior characteristics up to that point. It was believed that the subject had undergone considerable improvement in the past 2 months, and that the change was ongoing. However, attitudes of dependence upon the parents were minimal, and the relationship itself gave the impression of being superficial, lacking in any depth.

The parents exhibited great anxiety that 'T' might be autistic, and their motivation in seeking therapy was high. I told the parents that they need not capture their son's condition as being definitively autism, but that because he harbored the risk of being autistic, proposed mother–infant psychotherapy in order to enhance interpersonal relations between mother and son. Thus, mother–infant psychotherapy was started with the consent of both parents.

Course of therapy

Therapy continued for 1 year and 6 months, in the form of weekly sessions generally lasting about 50 min. The course of therapy thus provided could be classified into four stages.

Stage 1: sessions 1~4: At the start of therapy, the child's play was stereotypic, while the mother's actions were limited, and the mother's approach was met by T's avoidance. However, perhaps due to even marginal settlement of the mother's fears in the second session, T exhibited considerably more dependent behavior towards the mother. Nevertheless, the mother's attitude was largely that of trying to involve T in play which she wanted him to engage in rather than following T's interests, many times provoking avoidance in T towards the mother's approach. Even in the fourth session, the mother's irritation and bewilderment at seeing T repetitively engaging in the same sort of play was strongly evident.

Stage 2: sessions 5~11: This period was marked by the gradual appearance of meaningful words. Suffering a nominal injury by bumping into something, T would exclaim pain and run to the mother for comfort. Mother–child interaction had become active, but the mother's attitude of trying to coach words into the child was still strong. The mother's principal worry at the time was T's terrible temper tantrums (session 5). She exhibited strong bewilderment at such unequivocal expressions of will by the child. However, T's attachment behavior towards his mother was becoming stronger, and he took to actively imitating his mother. The mother was also becoming capable of voicing words in tune to her son's actions (session 8). Although general passivity was pronounced in T's attitude up until then, despite lessening obsession towards any particular object, instances of spontaneous, active attitudes (e.g. refusing his mother's help when she tried to give him a push on a tricycle seeing him unable to propel himself forward as his feet did not touch the ground) were starting to be seen. At home, T had graduated from clinging on to his mother at all times to being able to enjoy interaction with his father, showing activeness befitting a young boy his age (session 10).

Stage 3: sessions 12~15: T's vocabulary showed steady increase. He would call his mother 'mommy' and me '*Sensei*' (teacher), even though it was still evident that his understanding of words was still superficial, in that the mother attempting to make him say 'mommy' by pointing to herself would provoke T into pointing at his own nose and saying 'mommy' (session 12). The mother was still entrapped by T's every action, wondering whether or not they might be abnormal which provoked great unease. When I pointed this out to her, saying 'You always worry about everything, and tend to see everything turning out for the worst', the mother started recounting her problems as a youngster. When she was in junior high school, she had suffered from alopecia areata. Before that she had even attempted slitting her wrist with a knife. The mother related these matters in a state of depression. Around this time, the attitude of coaching her child was still strong in the mother, and I continued to provide

unchanging support in making her try to solicit T's active interest instead. In response, although the mother had been complaining of strong anxiety at the start of the session that her child might remain this way forever, not making any improvement, she came to express change in her state of mind, saying that everything the child did was so dear and precious to her she almost wished he would not grow up but stay this way forever (session 14). With deepening feelings of unity between mother and child, the mother and T came to engage in many types of play together, and T came to eagerly absorb his mother's approaches.

Stage 4: sessions 16~21: Playing with his mother, T visibly enjoyed imitating his mother's words, even though the exchange had not yet reached the level of conversation. The exchanges were in the form of mother and child becoming one, and the mother enunciating words adopting the role of the child, which T would then eagerly take in as his own (session 16). The mother related how she worried about his lack of cooperativeness, recounting how T would show outright dislike and rejection upon seeing a neighbor (session 18). When I pointed out the mother's inability to totally immerse herself in instances of mother–child interaction, the mother responded by relating the difficulty she was having with people-shyness. She went on to say how she had always had trouble dealing with others from when she was in kindergarten, always overly conscious of the eyes of others. Her mother had been an asthmatic, in and out of the hospital from as far back as she could remember. She had never had her mother play with her, and so there had never been any instances in which she had been self-assertive. But then she had always believed that all she had to do was to exercise self-restraint, and that that was okay if it made things good for others. Entering junior high school, she was lured into a group of delinquents, although she disliked being in that position. She was desperate to get out. Once in high school, her parents separated, and her mother left home. Her brother and sister also left shortly thereafter gaining independence, so that it was just her father and herself. She had been seeing her mother frequently after the separation, but she recalled having been called a fool by her mother from when she was small. At the end of the session, she was even able to comment, 'It's as if I were being treated, isn't it!' (session 20). In the next session, she related how watching her child play, she had always felt driven by the belief that she had to break in there somehow. She had always felt that she was the one somehow being evaluated at all times, but that had finally ceased, saying that she now felt that all she needed to do was to behave as she had been, naturally speaking introspectively about her relationship with her child up until then (session 20). In the following session, the mother presented a calm, relaxed atmosphere, adapting most naturally to T's pace in dealing with him. Free of tension, both mother and son appeared truly content. T's steady acquisition of spontaneous words also left a deep impression.

Stage 5: sessions 22~39: Upon entry into the interview room with T leading, the mother asked, 'Can I come in too?' to which T replied, 'Okay'. The exchange was an example of how the mother had come to regard her son as an independent existence, an individual with his own personality (session 22). No longer butting in front of her child, she would look fondly at her child playing, and should she step in too far, she would even voluntarily apologize to her son. Given this transformation in relationship, it seemed that T was even starting to show a strength and sturdiness befitting a boy.

However, uncertainty in verbal expression in the form of reversal pronoun was still pronounced, such as in saying 'Come again' to me getting up to leave him, or in asking the cotherapist to help him with a puzzle, 'Me, do it please', meaning you do it for me. In contrast to the wealth in interpersonal relationships and affective responses, it could be said that an uncertain aspect still remained in T's state of language development (session 32).

T had become capable of enjoying active interaction not only with his mother but also with his father, and steady acquisition of words in the appropriate context was also noted. Although his verbal expression was still interspersed by the reversal pronoun, continuation of therapy became difficult due to needs arising from nursing the grandfather back to health, for which therapy was interrupted after session 39.

Development test results

The Tsumori-Inage Development Test was implemented. At 1 year 8 months, at the start of therapy, DQ was 78. At 2 years 9 months, 13 months after starting therapy, DQ was 83.

Case 2: Subject 'Y', male (3 years 2 months at first visit).

Chief complaint: Does not speak, shrieks, shows no response when spoken to.

Developmental history

Accompanying slight delay in somato-motor development, Y exhibited a hypersensitive aspect from infancy. At 18 months, he possessed a number of meaningful words, but that was lost before his second birthday. Instead, he came to emit fearful shrieks. At 2 years 6 months, he was taken for consultation to a welfare center for the disabled after referral from a local health center. Diagnosed as developmental disorder, Y was enrolled in a mother–child day-care program. Upon request by his nursery school teacher, I first saw the child at 3 years 1 month, from which time therapy was started which lasted for 1 year 6 months.

Characteristics of the mother–child relationship noted at first visit

The mother was small in frame, and appeared very young for her age. The mother's existence was a large focus of Y's attention, although he appeared unable to approach his mother directly. Instead, he would climb up toy stairs in the play therapy room, or gaze at his own reflection in a mirror. He displayed no strong interest in the view outside the window. He would approach his mother nonchalantly, but the mother was unable to respond appropriately to such moves. In due time, the child would approach his mother and start pinching or beating her, but the mother, unable to capture the meaning behind such aggressive behavior, would reject his approach needs with curt commands of 'Stop it! Can't you see that hurts?'. It could be seen that Y harbored desires to approach his mother amidst feelings of hesitation, which left an impression of the ambivalence he was feeling at being unable to approach his mother directly.

Diagnosis and therapeutic policy

Y's condition was believed to be autistic spectrum disorder,[19] for which therapeutic intervention was believed necessary, capturing the condition as a problem in mother–child relationship, or relationship disturbance.[20] Thus, mother–infant psychotherapy was initiated immediately in sessions lasting about 50 min. Therapy lasted approximately 18 months, with frequency of sessions being every other week in the first half, which was switched to weekly sessions in the latter half.

Course of therapy

Stage 1: sessions 1~5: Judging from the characteristics of mother–child interaction noted at first visit, it was judged that Y harbored strong approach-avoidance motivational conflict,[15] for which a holding therapy[21] was held in which the mother was persuaded to firmly cuddle her son for about 30 min. The mother's awkwardness in holding Y at the time was of particular note. In the 2 weeks until the next session, Y came to demand being held by his mother on outings. In the interview room, Y became capable of cuddling up to his mother without hesitation, and would repeatedly climb up on his mother's lap and, after some time, get back down to play with some toys on his own. In this manner, Y's attachment to his mother grew rapidly, even though the mother appeared unable to fully appreciate this difference in her son. The child would approach his mother and attempt to start some form of play, but the mother would be incapable of acting appropriately. Pointing this out to her, she noted, 'I never had anyone play with me as a child either. I think I spent most of my time quietly, alone. That's why I don't know how I should be dealing with him', or 'Shouldn't I be trying to get him to sit down and do something?', capturing Y's present state negatively. It was deeply impressive how overly sensitive to being evaluated by others she was, driven obsessively by the need to teach something to her child.

At home, T began exhibiting a condition reminiscent of rapprochement in seeking out to confirm the presence of his mother when she was not directly visible and going back to playing on his own. This coincided with the period in which the mother came to speak introspectively about how she was unable to play with her son (session 4).

During sessions, Y came to insistently demand play on the sensory-motor level which involved having his mother and me hold his hands and legs and swing him to and fro, imitating a hammock. At the end of one such session, the mother suddenly started speaking about how she had suffered from an eating disorder when she was in college. Looking back on her child-rearing, she noted, 'I am raising him just as I was raised myself. I've always been angry with him. My mother was constantly angry with me, too. So I was always anxious to please, behaving as my mother wanted me to, constantly wary of her moods. Subsequently, I was a good child. All I had to do until graduating from high school was to do as I was told. Because I wanted to get away from my mother, I left home for a dorm after entering college. But then, once I actually started living on my own, I felt so lost my feelings of dependency on my mother increased. But my mother rejected my needs. I reacted to that by not eating. Maybe it was a form of appeal to my mother.' (session 5).

Stage 2: sessions 6~11: Following the first confession, she continued relating through the next few sessions how helpless she had felt and how difficult things had been for her striving for independence following entry into college, after having been obedient to her parents up to that point. In the meantime, Y's interests started showing a gradual shift from the hammock play which he had been so insistent upon to a more manipulative mode of play (session 7).

Stage 3: sessions 12~14: The mother related strong dissatisfaction with her husband, and strong revulsion towards sex following marriage. But she also spoke about how she was grateful to her husband for enabling her to have her child (session 12). However, watching her son immersed in play in the next session, she commented, 'When (this child) becomes all excited, I worry that he might stay that way forever. So I become anxious if I don't adopt a somewhat detached attitude', exhibiting bewilderment and disbelief at the sight of her son totally absorbed in play. Nevertheless, by this time, Y had come to partake in spontaneous forms of play, one after the other, and he started speaking words of demand which were becoming distinguishable (session 13).

Stage 4: sessions 15~21: Seeing how Y continued to reject the mother in not going to her when she went to pick him up at the day-care facility, the mother's depression was becoming pronounced. I proposed pharmacotherapy to counter the depression, which the mother accepted. The medication was terminated after 1 week due to side effects, but perhaps in response to the active therapeutic intervention, the mother became markedly introspective around this time, relating unpretentiously, 'I think I've been dealing with this child in much the same way until now—regardless of when he was 0, 1, or 2 years old. I was just taking care of him. I had no idea of how I should really be dealing with him' (session 15). Perhaps due to moderation of the mother's defensive attitude, Y's approach and attachment to his mother became increasingly natural, so that for instance, he would run to his mother exaggerating pain upon running into a wall accidentally in play, with which the mother too was able to immediately empathize and even undertake the role of alleviating his anxiety, saying 'Pain, pain, go away'. In this manner, as sharing of affect became increasingly easier to establish between mother and son, the mother became capable of grasping Y's intentions, speaking to him or developing play in the proper context. Accompanying this change in the mother, Y's verbal activity became visibly animated, and differentiation of speech was also promoted (session 20).

Stage 5: sessions 22~34: The mother came to even touch upon the relationship between her parents, and she was able to speak on her own mother–child relationship with considerable detachment (session 27). Noting, 'Everything has become a lot easier for me. I think I am starting to understand what it is this child wants from me. Now, I don't spend all my time thinking and worrying. I've come to realize that brooding on things won't make anything better'. She indicated how she was now able to enjoy child-rearing to a certain extent. Around this time, when Y demanded that his mother spin around in a chair with him, the mother was able to undertake the role of making the play more fun by emitting appropriate vocal markers,[22] although somewhat awkwardly (session 32). Even though she would voice particularly pessimistic thoughts at times, she showed no great emotional disturbance, while attitudes of total concentration in dealing with her child were often seen.

Stage 6: sessions 35~43: Saying, 'My relationship with my own mother used to be one of fear, but that has become better too. I think I've come a long way to be able to speak about such things at all. I couldn't understand the situation before which was a source of great irritation', she related how she was finally becoming able to get over her relationship with her own mother (session 36).

Y had come to behave with great freedom, clearly relating demands to his mother with words or exhibiting natural affection towards his mother. Seeing Y's transformation, the mother too was becoming able to recognize and respect Y as an individual.

One-and-a-half years into therapy, treatment was concluded with my move to a different institution.

Development test results

The subject was tested by the revised Kyoto Scale of Psychological Development. The results at 2 years 6 months (6 months before starting therapy) were overall DQ 59 (posture/coordination DQ, 67; cognition/adaptation DQ, 65; language/sociability DQ, 26). At 4 years 7 months (conclusion of therapy), overall DQ 51 (posture/coordination DQ, 51; cognition/adaptation DQ, 54; language/sociability DQ, 45). Following termination of therapy, the subject received further care at a nursing facility for 2 years. At the end of this period, overall DQ was 58 (posture/coordination DQ, unestimable (above mental age 3 years 6 months); cognition/adaptation DQ, 53; language/sociability DQ, 63).

These results reveal that although delay in overall development remained unchanged, phenomenal

improvement was achieved in the areas of language and sociability, from DQ 26 to 63.

DISCUSSION

Clinical diagnoses of the cases

In both cases, considering that communication could not be established between mother and child and that the presence of repeated stereotypic behavior and marked delay in language development at the start of therapy, the pathological state of the children at the time in terms of the conventional diagnostic framework would probably be pervasive developmental disorder. However, as seen through the course of therapy, the pathological state of children in infancy is still largely reversible and rapid improvement of autistic behavior is possible through appropriate therapeutic intervention.

In light of the particularly high level of reversibility during early infancy, it is believed that one should refrain from strict application of diagnostic frameworks constructed from standpoints of individual disability, while thinking of appropriate therapeutic intervention capturing the condition as a relationship disturbance is probably the most practical approach.[20] It is believed that when relationship disturbances in infancy, such as those presented in the present report, become stabilized, they bring about irreversible changes on the part of the children, which then give rise to the various pathological states of developmental disorder.

For these reasons, we decided to capture these cases within the framework of autistic spectrum disorder,[19] which encompasses the full spectrum of autistic conditions as the name implies.

Approach-avoidance conflict as noted in autistic spectrum disorder and therapeutic intervention

Although the primary issue in the concept of autism conventionally has been captured as disturbance in affective contact,[1,5] it has become known through recent studies on attachment in autism that forms of attachment behavior do exist in autism.[23–27] As indicated in those studies, a nonchalant desire for approach towards the mother could be seen from the first visit in the two cases presented in the present study, although mother–child interaction was characterized by the mothers' inability to recognize the approach resulting in inappropriate reactions on their part.

Richer states that approach-avoidance motivational conflicts arise in the child out of a vicious circle in the mother–child relationship, speaking from the standpoint of ethology.[15] In other words, in children prone to strong frustrations, fear, or anxiety avoidance is triggered when the parents actually attempt to embrace them despite the approach needs they harbor, due to exceptionally strong avoidance needs. Furthermore, their being left alone by their parents following such avoidance behavior in turn triggers approach needs, leading to repetition of this vicious circle. Richer himself supposes the presence of hypersensitivity on the part of the child giving rise to extremely strong frustration, fear, or anxiety as the backdrop to approach-avoidance motivational conflict. Given the ease with which the environmental world can take on persecutory contexts in cases of autistic spectrum disorder,[13,14] it is easy to see how such subjects readily fall into such states of conflict, which are probably determined largely by biological factors such as individual temperament.

Because both cases presented here were entrapped in the vicious circle of approach-avoidance motivational conflict, my first objective in therapy was to put an end to this circle and alleviate the conflict. In case 1, therapy took the form of explaining to the mother what the approach needs of the child were based on and providing guidance in ways of dealing with those needs. The mother often adopted attitudes of bewilderment and irritation towards the infantile behavior of her son, and active interaction between mother and child could not be readily promoted. Watching her son's behavior overwhelmed the mother with anxiety for the future, always making her view the present state in a negative way. Taking this up within psychotherapy from a psychodynamic perspective allowed for gradual clarification of the internal representation of children within the mother herself.

In case 2, I prescribed a holding therapy[21] for alleviation of the approach-avoidance motivational conflict between mother and child. Ambivalent behavior on the part of the child was clearly ameliorated by this attempt, followed by rapid promotion of attachment behavior towards the mother. However, it was also demonstrated through the course of therapy that in both cases, affective communication between mother and child did not improve so readily.

Affective communication between mother and child and the mother's internal representation

Mother–infant psychotherapy was conducted in both cases, which brought to light the internal world of the mothers in the course of therapy. In addition, this therapy clarified one aspect of the factors impeding affective communication between mother and child.

In case 1, the mother had no recollections of having been precious to her own mother from infancy, and

had behaved as a good child, always conscious of the eyes of others. Because of this, she was exhibiting strong bewilderment and hesitation towards her child's expression of strong will or outright affection.

Similarly, in case 2, the mother had been raised strictly by her own mother, and she had listened to what her parents said at all times. Because of this, the mother related that she had always behaved in ways in which she would be regarded by others as a good child. For this reason, she was exhibiting bewilderment at demonstrations of affection by her own child, or showing outright wonder, unable to understand why her child could behave so willfully. As such, it became clear through the interviews that in both cases there existed a large problem in attachment between the mothers themselves and their respective mothers.

Main *et al.* indicated that the quality of past attachment experiences of the parents with their own parents is readily subject to intergenerational transmission into the present attachment relations between mother and child.[28] It is seen that this is true in these two cases, with the quality of past attachment relations being heavily reflected in the present mother–child relationships.

Lebovici explains that there exists within a mother facing her infant, representations of three infant images (the real infant, the imaginary infant, and the fantasmic infant) and that these three infant images appear intricately entwined within the real mother–child relationship.[29] When a mother deals with her infant in reality, the mother sees the actual infant in front of her at the conscious level of her mind, while an image of infants as she has imagined from her own youth is present at the preconscious level, while at the unconscious level, unconscious memories from her own infancy are brought forth and projected upon the child. Should her own experience from infancy existing at the unconscious level be one accompanied by some form of distress, it is reflected back upon the real mother–child relationship in various forms.

The mother–child relationships in early infancy of both these cases were characterized by unfulfilled dependency needs and strong restraint, and it can be seen that in dealing with their own children, unconscious memories from those times were recalled and their own past infant images were projected in various forms. In particular, the mothers were seen to display reactions of non-acceptance towards outright demonstrations of dependency behavior by their children. The infant image presenting their attitudes towards their own mothers in the past was projected upon their own children, leading to their attempt to deny the image of their children as they were in reality. Exactly how difficult it is for such mothers to empathize with the feelings or intentions of their children in reality when they are dominated by such unconscious memories was clearly demonstrated through the course of therapy of both these cases.

It has become known through studies in infant psychology today that infants are capable of organization of the environmental world in their own way through primordial perception modes even before acquisition of the language function.[11] Experience organized at the level of affect in such early infancy is later reorganized following acquisition of language function, but the important point is that while affective experience is exceedingly peculiar to each individual, reorganization through the function of language inevitably imbues a public or generalized nature for conveying universal meaning.

In this process, the caregiver takes on the role of sharing as much experience with the infant as possible, and feeding back such experience to the child laced with meaning as applied within their own cultural framework. Therefore, the point of relevance becomes the accuracy with which the caregiver is able to share in the quality of affective experience with the infant, and the precision with which they are able to interpret the experience in words. Inability of the caregiver to empathize with the feelings or intentions of the infant, or repeated approaches by the caregiver out of sync with the feelings of the child harbor the danger of giving rise to great deviation between the quality of the infant's affective experience and the experience through words. This is primarily a danger inherent to the language function itself,[11] which makes it especially desirable that reorganization of experience within the infant takes place, making use of common modes of experience with as little discrepancy between infant and caregiver as possible.

Thinking along these lines, it is readily seen that affective communication between mother and child is destined to run into difficulties when the mother is dominated by the fantasmic infant image grounded upon the mother's past experience, in a relationship in which she cannot share in the feelings and intents of her actual infant. It must not be forgotten that the infant, in attempting to obtain clues for interpreting affective experience from the mother, in the context of the well-known self-regulatory other,[11] means subjecting the infant to the danger of being totally manipulated by the mother. As such, the course of mother–infant psychotherapy I attempted in the cases presented also demonstrates that bringing about transformation in the internal representation of the mother herself was an indispensable factor in

promoting affective communication between mother and child.

However, a point which must be stressed is that the mother's problems cannot simply be regarded as the sole factor giving rise to the disturbance in affective communication between mother and child. Evaluation of the individual factors reveal that in case 1 episodes indicative of extreme sensitivity are recounted from birth, while in case 2, ease of handling, in addition to absence of people-shyness or tagging along are noted. As such, it is surmised that both cases harbored some sort of biological vulnerability from the start. It is easy to imagine the presence of such biological vulnerability giving rise to various difficulties pertaining to child-rearing. Because both mothers held very high ego ideals, both were prone to capturing the infantile or hypersensitive behavior of their children negatively, which is believed to have functioned strongly as a factor impeding establishment of proper affective communication between mother and child.

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