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Witch-mother is which? The potential role of the analyst in facilitating authentic motherhood

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Abstract
This paper explores challenges in the treatment of women suffering from disturbances in maternal identification. A review of the psychoanalytic and developmental literature focuses on the frequent finding of early-onset mother–daughter relational disturbance involving maternal narcissistic fragility and exaggerated dependency needs, intergenerational trauma, and related psychopathology including mutual affect dysregulation. A case example of a young woman with a severe anxiety disorder is presented and discussed to illustrate the challenges to the traditional psychoanalytic technique. This patient avoided pregnancy into her late thirties and entered analysis with feelings of inauthenticity, characterological masochism, and a "secret mission" to unmask the witch recurring in her dreams. Through an elaborate working-through of negative maternal transference, the analyst and patient saw through the birth of the patient's authentic self, a new approach to her career, her relationships with men, and her anticipation of the birth of a child by the sixth year of treatment. The author posits that psychoanalytic technique benefits from contemporary, attachment, and trauma research that supports the analyst's playing a more active role in approaching, co-regulating, tolerating, and integrating avoided affects and memory traces that are associated with early-onset relational disturbances worsened by the effects of violence, maltreatment, and loss.

Key words: *pregnancy, maternal identification, negative transference, intergenerational transmission of trauma, mental representations.*

> Kindly examine the picture … Which lady is the witch? That is a difficult question, but it is one that every child must try to answer." (*The Witches*, Chapter 13; Dahl, 1983)
>
> "Listen," she (my grandmother) said, "I have known no less than five children who have simply vanished off the face of this earth, never to be seen again. The Witches took them."
>
> "I still think you're just trying to frighten me," I said.
>
> "I am trying to make sure you don't go the same way," she said. "I love you and I want you to stay with me."
>
> (*The Witches*, Chapter 1; Dahl, 1983)
>
> "Just try and stay out of my way. Just try! I'll get you, my pretty, and your little dog, too!" (Wicked Witch of the West in *The Wizard of Oz*; Langley, Ryerson, & Woolf, 1939)

This paper addresses the brave struggle that many women face upon entering psychoanalytic treatment – before, during, and after pregnancy – so as to be able to become a mother unlike their own. This struggle involves their facing frightening affects that are linked to mental representations of their own often narcissistically impaired mothers. Our patients often report feeling as if they are being held prisoner by a witch in a heavily defended tower "for their own good" with no clear way out. And thus an aspect of the transference frequently involves an expectation that the analyst will become a Prince or Fairy Godmother who comes to rescue them.

Parallel to the intrapsychic challenge of freeing themselves from their psychic imprisonment, these same women are often now up against the biotechnological challenge of assisted reproduction as their conflicts lead them often to avoid, procrastinate, and postpone their decision until their natural biological capacity to bear children has waned. Women nowadays can have children when their predecessors' conflict-compromise would have resulted in their resignation to never becoming a mother. Recent possibilities for *in vitro* fertilization present both hope and dread for these women who, after sitting on the fence, decide, often under biological time pressure, to have children.

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Therèse Benedek (1949) wrote in her paper "The psychosomatic implications of the primary unit: Mother-child" that "The behavior manifestations which are usually accessible to psychoanalysis reveal that the woman's identification with her mother motivates her attitude toward motherhood and determines her behavior toward her children" (p. 142). The successful resolution of intrapsychic conflict around our patients' attitude toward motherhood is essential for these women to escape the spell of the witches that would keep them as child-daughters, frozen in development, and guarded in the figurative tower, or that would transform them into fellow witch-hags. Our patients' struggle can lead to the successful reorganization of their mentally represented past and present real relationships with their mothers – and significant others – but also to the rejection of maternal identification all together. Our patients at best allow themselves to fulfill their own desire to become a mother – and at worst sacrifice their experience of motherhood in the service of maintaining pathological dependency on her own mother. Becoming a mother can simply feel too dangerous; often at the manifest level, it involves mortal menace posed by having a baby who can kill the mother, or becoming the mother who can kill the baby.

A major theme in the treatment of such patients is the sense that the mother-to-be patient during the analytic process feels as if she is an undercover agent betraying her own mother to the analyst. She feels that she is committing treason towards her own mother simply: (1) by allowing herself to become curious and critical about who her mother really is – involving taking distance from her (i.e., a normative part of adolescent development that is derailed), and (2) by desiring to become a mother herself. To do so, the patient may disguise herself as a bad object in order to become a good mother incognito – at an enormous cost of authenticity – to the point at which even she can no longer discern herself. As my patient described later in this paper would say, "Witch-mother is which?": her real mother now or during her childhood, the mother in her mind, or herself as mother or mother-to-be.

The literature has described the process of becoming a mother once the baby is born and during pregnancy. Daniel Stern (1995, pp. 28–29) offers this description:

> With the arrival of the baby, the new mother is likely to start consciously or unconsciously to re-evaluate her own mother. Here, too, well-established representations are drawn into that postpartum crucible of change. Most often new or at least more elaborated and understood networks of schemas of her own mother emerge. These include her own mother as mother to her when she was a child, as a wife, as a woman, and as the grandmother to her own child.

Stern then turns to attachment research in an effort to understand how some mothers with histories of poor relationships with their own mothers either emerge successfully or become vectors of transmission of a disturbed attachment.

He lists several essential themes that must be addressed to become successful: growth, primary relatedness (authentic relatedness), supporting matrix, and identity reorganization themes (Stern, 1995). All of these themes require what Stern calls a "reactivation and reorganization" of the new mother's relationship with her own mother. He points to situations in which the new mother "may have to pay too high an emotional price to maintain the supporting matrix … the price is usually in terms of self-esteem, autonomy, independence, or dignity" (Stern, 1995, p. 179). The "reactivation and reorganization" of which Stern speaks can equally be considered to begin during pregnancy or even before. This process is involved in the woman engaging consciously in becoming pregnant and recognizing that she is pregnant.

While attachment theory is helpful to understand in general terms what promotes risk versus resilience, I assert that, before and during the pregnancy, treatment demands the psychoanalyst's understanding, clarification, and confrontation of the individual woman's psychological defenses that promote incoherence of a mother's-to-be mental representation and narrative thereof concerning her own mother.

Arietta Slade and colleagues (Slade, Cohen, Sadler, & Miller, 2009) state, "For the pregnant woman, becoming a mother invariably activates her internalized object relationship with her own mother" (p. 25). Ideally, one of the ways that a mother comes to feel like a mother is by "identifying with her own mother." And citing Bibring (1961), Slade et al. go on to say that often the reworking of woman's internalized and actual relationship with her own mother over the course of the pregnancy "will allow a woman to see her own mother in a more positive light and to develop a vision of herself as a mother" (i.e. with her mother together) (2009, p.25). If this process does not occur, a disturbance in the mother–child relationship is likely.

Very little has been written about the processes that allow the woman to assume consciously the act of becoming pregnant, the decision to become a mother before she is pregnant. Whether a woman who decides to become a mother can or cannot become pregnant and have the child may even be less important than the integration of an acceptable maternal identity before the ability to have a child is

known. An extreme example of a maternal identity disturbance is found among women whose defenses against maternal identification are so strong that they deny any interest in – and may even scorn – maternal behavior. As an example of the latter, we have Simone de Beauvoir (1949), who wrote in *The second sex*, "*L'amour maternel n'a rien de naturel*" ["There's nothing natural about maternal love"] (p. 323). De Beauvoir asserted that motherhood was imposed on women and forced them to become alienated from themselves. Lest there be any doubt about the origin of her position, in writing about her mother's death in *Memoirs of a dutiful daughter*, de Beauvoir (1958; English edition, 2005, p. 58) described their relationship: "I learnt from Maman to efface myself, to censor my desires, to say and do exactly what ought to be said and done."

As Stanley Coen (1992) points out, incomplete separation–individuation tends to be exploited defensively. Parent and child, afraid of loss and destruction, will tend to form object relationships that are narcissistic in one of their aspects. That is, the self and other will be defensively confused, mixed up to lessen the fear of losing or destroying someone who is fully differentiated from oneself. According to Coen, the analyst must weather through with the patient the dependent maternal transference, recognize, tolerate, and integrate the rage that is implicit in a relationship in which a mother has not assisted her daughter's forward development to fill her shoes to succeed her as a mother herself.

According to Mahler, Pine and Bergman (1975), this conflict is manifest in observable mother–infant interactions at least as early as 15 months in what the authors name as the beginning of the rapprochement phase. As Gergely (2000, p. 1197) underlines:

> Along with the beginning awareness of separateness came the child's realization that mother's wishes seemed to be by no means always identical with his own … or contrariwise, that his own wishes did not always coincide with mother's. And so in developmental terms, we can also understand the phenomena that I will describe as a disturbance with developmental origins that go back at least as far as the toddler's literal efforts to turn, walk, and to run away from and run toward her mother.

The case of Elaine

The following case-report describes a young woman who began in psychotherapy, once, then twice per week, and whose treatment, after two years, evolved into a four-session per week analysis on the couch of six years' duration. The final year of her analysis would involve a successful pregnancy and achievement of motherhood. This patient began as one of my control-cases during my training and continued thereafter. This is, as it were, a mother–infant case without the infant yet present in the flesh. The baby was, however, more than psychically present for most of the treatment.

Elaine a 35-year-old, single, Brooklyn-raised, unemployed attorney living in downtown Manhattan was sent to me by a colleague who had been recommended by the patient's gynecologist because Elaine wanted a therapist who would be within walking distance of her apartment. Elaine was agoraphobic and at the time of referral was experiencing depression and panic attacks that she had confided to her gynecologist during a routine examination after her 35th birthday.

My first impression of Elaine when she walked in was one of a fashionably dressed, slender woman. She had long black hair covering one eye and large dark eyes, and appeared at least 10 to 15 years younger than her age. She had an oversized white blouse, very tight black pants, shoes that were like ballet slippers, and a very loud clanging charm bracelet and a huge purse. She seemed like a college student, who clearly wanted to draw attention to herself but at once remained partially hidden behind her hair, and carried herself with a posture suggesting low self-esteem, fleeting eye-contact of shyness, and a reserved, self-effacing, at times cynical and overly self-mocking humor. Her movements were graceful as if she had studied dance. And when she sat down, there was something about the way she organized herself in the chair, her body turned to the side, her hands clasped on her lap that reminded me of a cat, her favorite animal, out in the cold approaching a warm window with the weight of her body.

She began to speak in a very low and serious voice as I asked her what brought her to see me. "My whole life is frozen," she said, "I can't move ahead in anything. I'm almost hiding out … I'm having a hard time doing things I have to do, to get a job and improve my personal life."

Elaine was living with Mark a man who was 15 years her senior and with, of course, a cat – a sickly, "abused" cat that she had adopted from animal rescuers despite its having a chronic congenital illness requiring daily treatments. After turning down an engagement in her early twenties, having graduated from college one year late because of incomplete grades, Elaine decided to go to law school. Despite her late applications, she successfully gained acceptance to one of the three law schools to which she had applied that were within walking distance of her apartment, which also meant of her mother's apartment. Her mother, an Argentinean woman in her late sixties who had studied in Paris and then come to New York in her

late twenties to become a fashion stylist, lived two blocks up and one block over from Elaine's apartment. At the time of Elaine's treatment, her mother worked part-time in an upscale Manhattan women's boutique – yet still introduced herself as a "stylist" when meeting new people (even though she had not done anything of the sort since before Elaine had been born).

Through one of her mother's many social connections, Elaine met Mark. At the time we started the treatment, Elaine had lived with Mark for eight years. Elaine described Mark as a highly cultivated and "distinguished" man who was somewhat maternal – "he has wonderful taste and has created a very warm home environment for us both." He was a classical music producer and very successful, with two ex-wives and a series of girlfriends, all of whom remained his friends and all of whom he insisted be friends with each other at large holiday feasts. He had no children, nor a desire to have any children. "This was understood from the beginning," Elaine said; "neither of us wanted children." Although not clear at that time, it became clearer later on that Mark drank too much and was "off and on," insisting on making independent plans and then suddenly becoming intrusive and controlling. He subtly interfered with Elaine's very restrained efforts to exert some independence.

It became apparent after a number of sessions that, since the beginning of their relationship, Mark had maintained an erudite friendship with Elaine's mother, compared recipes with her, and exchanged CDs of favorite classical artists. When Mark, Elaine, and her mother would often go out together to concerts and dance performances, Elaine commented that her mother enjoyed the idea that Mark was "her" boyfriend too and they were all out for a "threesome."

Elaine's relationship with her mother

Elaine's mother was a palpable figure in the treatment room and nearly more than that. She threatened to come to Elaine's sessions more than once so as to tell me what was "really the matter with her daughter."

There were many ways that Elaine had to maintain an impression of being inept and "bad" at whatever she did. She was a dutiful child-daughter who praised her mother for her cooking and her style – Elaine told me in a hushed whisper (as if her mother were physically in the room listening) that, in fact, her mother had never become a stylist and came only close when she served as a temporary replacement for a wardrobe assistant to a fashion stylist before becoming pregnant with Elaine. Her mother had hinted more than once that she had given up her career aspirations to raise Elaine, who said, "My mother thinks she is my personal stylist." Elaine stated that her mother would often say, despite Elaine's obvious own fine taste for high fashion, "You are not doing your looks any good by dressing like you do."

Elaine's mother would buy her clothes, furnishings and art objects. At the start of the treatment, Elaine would try the clothes on and accept the furnishings but not wear or display the gifts. In the course of the treatment, she asked her mother to take back the gifts. Her mother said "No." Only some three years into the treatment, as a mark of progress in her separation–individuation did Elaine donate a number of the gifts to charities without telling her mother. At the outset of the treatment, it was not clear that Elaine would ever be able to get to that point. Not long after Elaine started twice per week psychotherapy, about six months into the first year, she told me with a smile that her mother wanted to come with Elaine to meet me – but that her mother was already sure that she had found Elaine a better therapist.

Would this be a case, I would ask my supervisor, in which the patient's masochism was so overwhelming as to prevent any significant change? What sustained my supervisor's hope and mine was Elaine's capacity for humor about her relationship with her mother, as well as her sense of her mother's real potential for danger and destruction that emerged over time. Elaine began to tell me of the sudden and unpredictable bouts of violence that her mother manifested. Elaine described most vividly an evening during which she told a taxi driver to change routes so as to avoid traffic. Furious that Elaine had not consulted her mother first, at the red light and without warning, Elaine's mother jumped out of the cab. Elaine felt horrified and helpless. There was no third, no father, necessary in the picture, but of course this dimension exists and renders more complex the pre-Oedipal mother–daughter relational disturbance.

Something else we learned was that Elaine could not tell her mother that she had passed her bar examination to qualify as a practicing attorney in New York (paradoxically, much as Elaine's mother could not admit that she had never become a stylist). Both lived lies that contributed to each feeling inauthentic and unaccomplished. Elaine withheld turning in a simple attestation requiring only her signature and a notary's, without which she could not be licensed to practice law. She felt and acted with others as if she were an attorney manqué, at times making me wonder if she had indeed failed the test or cheated or done something else to disqualify her and was hiding her "truly bad self."

About a month after the treatment had started, Elaine went with her boyfriend to his sister's home in California but came back alone, more depressed. Her relationship with Mark began to show signs of trouble.

Elaine then reported her first dreams of the treatment. She had replaced both Bette Davis and her troubled young ward in the movie *Now, voyager* (Wallis & Rapper, 1942), which is the story of a wealthy heiress, Charlotte, born as "an unwanted child" to a narcissistic mother. After recovering from a depressive episode in a sanatorium and cared for by a benevolent psychoanalyst, Charlotte meets a divorced man and his daughter, Tina, on a therapeutic cruise to Europe. She recognizes the child's suffering immediately as due similarly to a neglectful, narcissistic mother, and finds meaning and hope through this new relationship as a substitute mother to Tina. Elaine could not tell if she was in a "real movie" or whether it was a dream – Claude Rains, the actor who played Charlotte's psychiatrist, had my mustache. Charlotte and Tina were both Elaine at different ages. The dream foretold of hope for a repair of damaged mother–child relationships but also for a fatherly-psychiatrist third who would intervene and help Elaine separate and individuate from her mother.

Intergenerational trauma and the role of men in mother's life: What made it so hard for Elaine to distance herself from her mother

From the beginning of the treatment, in the evaluation phase, it was difficult, despite hearing about the many awful things that Elaine's mother had done and was continuing to do, not to be forgiving and even compassionate for this mother. She had been repeatedly wronged. Elaine's mother's biological father had been a resistance hero in Italy and had "disappeared" during the time of Mussolini when Elaine's mother was an infant. After waiting for nearly three years for her husband to return, Elaine's maternal grandmother had found passage to Argentina and married a Jewish holocaust survivor she had had met on the boat to Buenos Aires. This man turned out to be extraordinarily physically, emotionally, and verbally abusive of Elaine's maternal grandmother and her mother. He too had been a trauma survivor so was "forgiven."

Elaine's own father, a Brazilian man from a Sephardic Jewish family, was a respected scientist and university professor known for his good looks. While always kind and nurturing towards Elaine in her memories, he worked long hours (Elaine's fantasy being that he perhaps had buried himself in his work to avoid Elaine's mother). Elaine recalled, with a quiver in her voice as she told it, that her father had a volatile temper with her mother. Elaine recalled reluctantly that her mother seemed to provoke him to the point of physical violence on several occasions, the worst of which was when her father hurled a jar of steak sauce at her mother's face during dinner and broke her nose in front of Elaine, when she was nine years old. Elaine recalled that the couple had to invent a story so as not to let on that her mother's black and blue, bleeding nose had been due to domestic violence.

Four stormy years later, when she was 13, Elaine's parents had divorced. Neither parent had remarried or had other children. Elaine understood her parents' relationship as something akin to Chinese fighting fish. They longed for each other but had to stay apart to be together. Elaine's mother was a tormented, traumatized person, with chronic insomnia, crying spells, flashbacks, and marked separation anxiety – she at times awakened Elaine in the night to share her bed because of nightmares she was having. Her symptoms spoke of early-onset chronic exposure to violence that only would be confirmed later in the treatment.

Her mother's unpredictable disruptions caused trouble on nights before school examinations. Elaine's father died during her first year of law school – another difficult disruption for which she blamed herself, having given consent to surgery in an effort to save his life after a ruptured aortic aneurysm. He left his entire estate, including property, exclusively to Elaine. This would allow Elaine, who quite efficiently managed her father's estate, to "act" as if she were an unemployed and unemployable failure while living comfortably. Difficult for Elaine in a number of ways was the fact that her mother was not mentioned in her father's will. If one would like to emphasize an Oedipal dimension to this story, this would be just the tip of the iceberg, as Elaine's mother, who had to work hard to make ends meet at the boutique, was furious and at times unable to conceal her envy and jealousy of her own daughter for reasons now grossly apparent to both women. While Elaine's mother preferred a life without a man, Elaine had found herself "never without a boyfriend" from the age of 15 on.

Putting into operation "undercover mother"

The first six months of the treatment involved listening to the multiple and contradictory pieces of the story of Elaine and Mark and her mother, often in a dissociated or affect-isolated way with the appearance of wide eyes like a deer facing headlights on a long dark road. The oncoming car was Elaine's own rage. And it was unbearable, given the fear, shame,

and guilt that this affect elicited. To be angry with her mother was to blow up, to slap and batter her mother. I do not think that Elaine would have been able to tolerate the affects that came up in the first two years of treatment without the help of medication (a serotonin reuptake inhibitor) during this time, as well as my willingness to return her phone calls between sessions in response to her panic attacks.

A breakthrough occurred six months into the treatment. One strong point of identification with Elaine's mother was gourmet cooking. It was one of the very few areas about which Elaine's mother gave explicit compliments to her daughter and showed pride and nurturance in passing down recipes. Of course, there was also overt competitiveness, but playfully so, which emerged around big holidays like Thanksgiving. In this context, Elaine came in eager to report a dream as follows. A friendly older lady with a "bright green complexion" is stirring a large pot of stew in Elaine's kitchen. Elaine eager to see what smells so good looks into the pot and sees to her horror, that this "familiar stranger" is stewing a writhing mass of half-alive poison frogs.

When asked to tell me what came to mind about this dream, Elaine laughed. She said, "I know what you're thinking Dr. Schechter! You are thinking that the woman was my mother and that she is really a witch!"

When I pointed out that this was Elaine's own thought, she looked at me head on and stated, "Well, I thought you were going to say that and I guess that we have both learned that my mother can be toxic!" The new "we" who learn together implies a benevolent third eye and ear. The humor shows evidence of integration and tolerance of dreaded affects. The projection "you are thinking … " is a veneer.

There was a new depth to all the object representations, and clear changes occurred in Elaine's life. Without telling her mother, she took a job as a legal assistant for a battered women's and children's advocacy group – first as a volunteer, and then as a paid assistant. She turned in her disclosure form to the Bar Association and was able to leave the agency as a paralegal and join another similar one as a staff attorney. She told Mark that she wanted to have a child, and noticed that thereafter he ceased all intimacy and began to travel more frequently.

Elaine left Mark and almost immediately embarked on a series of love affairs, often beginning with a flirtation with a stranger in the local coffee shop or at the newsstand. And yet Elaine, who on the one hand maintained a profile of agoraphobia as her "real self," never felt that the Elaine who picked up men in the neighborhood was "real" but rather "playing a role," often sexually orgasmic but in a dissociative or disavowed state. The relationship would invariably end as it came time after a few encounters for Elaine to tell more about herself – who she really was.

During the second half of the second year of treatment, she began to feel increasingly inauthentic, to the point at which she felt during panic attacks that she would be unmasked as a fake. Simultaneously, Elaine found her mother to beginning to have increasing separation anxiety and demanding that Elaine spend evenings with her and go on extended trips with her, including to take a tour of Gothic abbeys in Britain, during which Elaine was fascinated by the life-like marble effigies on the tombs of noblewomen.

At the end of the second year of treatment, Elaine moved into her own apartment. She was without a man for the first time since she had left home. The apartment she found happened to be across the street from her mother. "It was pure coincidence," she said. Elaine decided out loud that she decided not to give her mother the key to her apartment.

By this point, two full years after her first session, I had already recommended psychoanalysis, and Elaine accepted. But she was frightened of the couch. She said that she knew that I treated children in my office and that children had lice. Elaine described how her mother had forbidden her to try on costumes in the dress-up corner in kindergarten because of a fear of lice. Children were dangerous! Elaine now transferred this contamination fear to the paper-towel on my couch. Meanwhile, sitting up and facing away from me, she reported dreams of finding frozen dolls that want to come alive, and nightmares of losing hair and teeth.

After my summer vacation, Elaine began to recline on the couch (three months into the analysis), stiffly, with her hands clasped over her abdomen and her eyes often closed. The first dream on the couch: her mother found a photo of a little girl and insisted that it was Elaine. Elaine, however, knew that it was not her but "felt persuaded" to believe that it was herself. She found the photo and her mother's response to it both "unappealing." She associated to feeling like a fraud and then seeing the tombs of the noblewomen on her trip through the British Isles with her mother. When I told her that I wondered about how rigidly she had positioned her self on the couch, she mimicked more explicitly the effigies she had seen and laughed, saying "Rigor mortis has set in."

Little by little, amidst this frozen watchfulness, Elaine began saying "No" for the first time to her mother's all-expenses paid adventures. She reported simultaneously dreams in which she went with her mother and took the suitcase and handbag that her mother had prepared for her, only to realize at the airport that she had no passport, wallet, or contact lenses. The journey and the analysis became one.

In the fourth year of treatment, the second year of analysis, Elaine moved from the back seat to the front passenger seat to the driver's seat in her fantasies. She took driving lessons. She dreamt that she so enjoyed driving that she became oblivious to pedestrians and started running people over. "Some looked like, I know you are going to nod of course, my mother." And in the fifth year, she met a man who she initially thought might be boring and conventional. "He says he wants to have a family," she said with a slight quiver in her voice. "And you?" I asked. "I do, but not right now … I don't think I am ready. I don't want to be like you know who."

Fraiberg, Adelson, and Shapiro (1975) "Ghosts in the nursery" clearly has been a cornerstone of psychoanalytic thinking about risk for intergenerational transmission of trauma. As clinicians, we all too often neglect factors that support resilience in the face of trauma, as evoked by Lieberman, Padron, Van Horn, and Harris (2005) in her paper the "Angels in the nursery," more specifically, positive attachment representations and maternal role models. One such "angel" in Elaine's life was her maternal aunt, her mother's younger half-sister who lived in Argentina and who had managed to escape her father's abuse. She had found a balance between having a career and a family and was considered, to the envy of Elaine's mother, as "the most successful" of the family. This aunt spent several summers as a college exchange student with Elaine after her parents had separated. She became more prominent as a benevolent figure in the treatment, as did one of Elaine's more nurturing mentors at the public legal agency where she worked.

An additional new phenomenon emerged at that point in the treatment that was linked to maternal care, just as her representations of important influences in her life became more complex, varied, and integrated: Elaine began to adopt increasing numbers of stray and abandoned animals, to the point that made it impossible for Elaine to take vacations and it threatened her love-relationship. "He says it's the ferrets or him." She kept the ferrets in a cage at a friend's house and avoided telling her boyfriend Bob about her analysis (bills had to be handed over not sent) and telling her mother about Bob.

Bob bore the brunt of Elaine's identification with the aggressor-mother. Needless to say, Bob was indifferent to Elaine's mother and, he being a serious candidate to become Elaine's life-partner, was felt "not to be good enough for Elaine." There were moments when it seemed that Elaine and her mother enjoyed putting down Bob's proletarian taste. Fortunately for Elaine, she had found in Bob a man who was relatively maternal and, like herself, masochistic. Despite her fears and her and her mother's attacks, there was little shaking him loose. And it was possible to look at how she was showing us in the analysis how her mother could be with her by how she was with Bob. She became more understanding. She bit her tongue when he wore his old worn sweater. She accepted his Valentine's Day present without cringing or laughing as she had done for her birthday gift. And she began to defend him when her mother made fun of him.

By the Easter holidays, in the fifth year of treatment, Elaine had agreed to find an apartment with Bob, and moved in with him six months later. The apartment was in her same building, a few stories higher. She claimed that she had got a deal on the lease that she could not refuse. I commented that it was hard for her mother and her to move on in their lives separately.

Elaine arrived at the new realization, in that same period of treatment, that Elaine's mother needed Elaine far more than Elaine needed her mother. And simultaneously, Elaine was able to say that she herself both wanted to become and could be a mother such as she herself had never had.

But alas, the reality of being over 40 with doubts over her fertility, reinforced by her gynecologist, cast a dark shadow over the treatment. Elaine enrolled in fertility evaluations with Bob. She feared he would leave her if she were to be found infertile. Bob made it clear that he wanted children and to be 100% biological parents. There was one failure after the next. There was the fantasy that it was indeed her mother who had been the witch, and that this witch had cast an evil spell that would not allow Elaine to conceive. Even more too, Elaine's career was taking off. She was up for partner in her firm. She began to fear that it would be "too much" should she become pregnant: "It might do me in," she chuckled.

It became clear, the more that I heard the story, that despite there being a "biological clock" version of reality, there was also a subtle enactment whereby Elaine was finding herself working late and too tired to make love with Bob on the nights when she was most fertile. "Older women are more likely to have complications … malformed children," she said, "even to die of eclampsia." Being an undercover mother is a dangerous mission. We spoke about the loss that Elaine would incur if she succeeded, all the disappointment and all the envy of a child who would have the wonderful mother that Elaine never had. Elaine spent nearly two weeks of sessions crying. She spoke little. She worried that I was deceiving her. She worried that I wanted her to have a child so it would be my success – so I could write about her as I am doing in this paper years later.

I, her analyst, was now the "witch"! I began to wonder, "Was I?" Elaine got me to doubt myself via

projective identification much as her mother got her to doubt herself. I could feel what it was like to be Elaine with her mother. Of course, I was required to write up her case. This was in the consent form she signed as a patient for my psychoanalytic training requirements.

There were both implicit fears and wishes. She wanted also to be my special child. "Am I a good or a bad patient?," she asked. She had reduced her workload. In between failed fertility treatments, she discovered that she was pregnant. Immediately, she panicked. "I can hide from my mother for only so long!" "What is the fear?" I asked. She answered, "I don't know – she will feel left out?" I replied: "Can you feel like wanting to leave her out? You want this to be your baby not hers. You don't want to tell her about your accomplishments in work, in your love-life, in your becoming a mother … " Elaine said, "She makes it awful."

It had become clear that Elaine was now rarely seeing her mother even though she lived across the street from her. Elaine, who knew exactly where her mother went every day, used the knowledge to avoid seeing her – as opposed to "running into to her unexpectedly." There were many messages on the answering machine, then hang-ups.

"It is hard for you and for her to move on with your own individual lives," I said, feeling like a broken record. "Well, I have been keeping something from you," she said. I was not really surprised; before the "undercoverness" could end, there had to be a bit of double espionage. She said, "Remember when I told you that I finally got curtains?" I did. This was around the same time she told me that she realized that her mother needed her more than she needed her mother. She went on: "I had this strange feeling in the apartment like I was being watched. And one night, like in the Hitchcock film *Rear window*, I turned the lights out in the living room and looked out of my window. I saw my mother looking at my apartment with a telescope. She told me that friends had given her one to look at the stars. But who looks for stars in Manhattan?"

The analysis was programmed to end two months prior to the birth. I had to leave my practice as I was moving to Switzerland to take my present position. I had announced my leaving four months previously and encouraged Elaine to begin a consultation with a colleague who did parent–infant work and then to transition to this person. She called that therapist, made an appointment, and canceled. "As long as you are here, I cannot see another therapist," she confessed. "But when you leave, I will get around to it," she said as if to reassure me. We talked about how she feared betraying me much as she feared betraying her mother, as if I, like her mother, would not be able to tolerate her moving forward.

During the last sessions, Elaine worried about how she would defend herself against her mother's criticisms of her mothering. The expression came up, "You sit back and relax, mom, and leave the cooking to me." This expression, reminiscent of the old advertisement for the Greyhound Bus Company – "Sit back and leave the driving to us" – made Elaine smile broadly and turn to look at me for a shared spontaneous laugh. Elaine began to feel that she could decide what she wanted to take from her mother and what she wanted to leave behind. She grieved for my departure even as I remained available.

After I left, I received first some emails, one reading: "My mother is listening to me when I tell her what to do … she is afraid that I won't let her have time with the baby." Then, after a period of no communication, a month after the birth, I received a birth announcement with photos. The card read: "I want to show you the baby, she is beautiful and she has a nice mother too." To this day, every holiday season, I receive a photo of Elaine's daughter. Elaine did engage in parent–infant treatment and saw that therapist individually on a weekly basis.

Discussion

Helene Deutsch in her 1947 book *The psychology of women*, Volume II, *Motherhood*, cited Abraham Kardiner's 1922 field studies of the cannibalistic Marquesa Indians in New Guinea. Kardiner had observed how mothers would already direct their jealousy towards their newborn daughters. Deutsch stated that Kardiner's description of how maternal ambivalence in a context of deprivation could lead a mother to perceive her unborn baby, her fetus, as an "endoparasite" such that the fetus would become a threat. Elaine, indeed, felt that she had been such a threat to her mother and feared that her unborn child-to-be would be a threat to her. We did not explicitly reach those very hostile and ambivalent representations until later on in the treatment when Elaine was finally pregnant.

When Elaine first began treatment, I focused with her only on good, idealized representations of her mother and her boyfriend. At the same time, I listened to Elaine describe her subjective experience as "frozen," mixed paradoxically with volcanic eruptions of symptoms: panic attacks, annihilation anxiety that would trigger phone calls between sessions. And I noted that Elaine appeared frozen and dissociated as she recounted her traumatic experiences with her parents and boyfriend. I felt alarm when she appeared

outwardly calm and distant, and thus experienced her communication as a form of projective identification.

During this opening phase, Elaine's discourse became more fragmented as I pointed out these repeated contradictions, together with their accompanying mismatched affect. I noticed that she manifested an oscillation in her feeling depressed and deadened (i.e., when she fused with her mother) with a feeling of terror and internal agitation (i.e., when she took some psychic distance with her mother, aligning with my role as an observing third, and began to describe her mother as incapable, with accompanying feelings of an intolerable aloneness).

As many maltreated children do, Elaine felt as if she were going mad. I was able to intervene to reassure her that for years she had fashioned a workable adaptation that denied her mother's difficulties and her own feelings in relationship to her mother, father, friends, and intimates. Now, she had begun to realize that this adaptation had come at a great cost that she perhaps would no longer be willing to pay. I told Elaine that, in the absence of attachment figures that could manage their own feelings and help her to understand and manage her own feelings, she had done what she could. The change from the former adaptation to a new solution was in fact terrifying to her.

My role as the analyst was to help her bear this terror by accompanying her through her intrapsychic journey as an observing, mentalizing third. I reassured her that I would not leave her alone with her terror, but rather support her efforts to become her own person who could hold our work in mind between sessions. I helped her tolerate helpless, frightening mental states both in words and in action. As her panic symptoms became overwhelming with an exacerbation of agoraphobia that threatened our sessions, I prescribed serotonin reuptake inhibitors to reinforce her efforts during the first few years of the treatment. She would at times take a taxi the few blocks to my office for her appointment to avoid both "crowds" and the possibility of crossing her mother's path.

Addressing the rage

The next shift in the treatment process involved Elaine telling me about very disturbing interactions with her mother and Mark, with very isolated, dissociated affect. I would often respond by saying, I am not sure how you feel right now in reaction to what you are telling me, but a lot of people in your shoes would feel furious at their mother if she behaved that way. Elaine at first often responded, "Strange that I don't feel angry. I am more surprised." I responded, "Surprised about something your mother has done in one way or another a thousand times?" The point was that, of course, the idealized mother would not have hopped out of the cab in the middle of traffic or hidden the patient's keys so that she would have to come back after leaving her apartment. But I, as the analyst, would also have to feel this surprise to know truly what being with her mother was like.

One day, Elaine came in, reclined on the analytic couch, and then turned around angrily and abruptly; "Are you chewing gum?"

I answered, "No. What makes you ask?"

"Were you before I came in? I smell gum!"

"And if I were chewing gum?" I asked.

Elaine said vehemently, "I find it disgusting. I can't stand that people chew on the same thing over and over again and then just spit it out somewhere."

Feeling ashamed and lowly, I responded, "Well, I don't suppose it is all right to have a Tic Tac? But gum or Tic Tac, are you showing me what it is like to be with you and your mother?"

"My mother and I both hate gum-chewing."

"I thought that might be the case! I was surprised that you turned around and looked at me so intensely and angrily. I am reminded of your saying that you feel surprised by your mother."

"I did just act like her, didn't I?" Elaine responded with a laugh and glint of recognition that she had just successfully integrated our curiosity about her behavior and the workings of her mind.

As I came to understand Elaine's representations of her mother in all her complexity, and thus Elaine's self-representations too, I was able to see Elaine become at times overwhelmed by horror as she realized not only that the mother that should have been both protecting her and fostering her development had not done so. I also saw that she herself had invested so much of her life in maintaining a relationship with this mother that there had been little time left for her own with others.

What followed was Elaine's realization that her father had been more than happy to leave her with her mother so as to free himself of his wife's dependency. Furthermore, Elaine showed a look of horror in verbalizing that even "my own boyfriend was in league with my mother!" Her expression reminded me of the character of Rosemary Woodhouse in the film *Rosemary's baby* (Polanski, 1968), based on the Ira Levin (1967) novel of the same name. In that story, Rosemary, pregnant with the devil's spawn, discovers that everyone – even her obstetrician – is a witch (i.e., "All of them Witches!"). There is no escaping, "No mother-ectomy possible," as I interpreted.

There is a point at which the patient feels the horror of having a caregiver that would keep the child from

growing and becoming her own person *and* would bewitch or paralyze others so that they would not or could not curtail mother's power – and we feel this horror as analysts too. The danger, of course, is entering into the sadomasochism and wishing to rescue the patient from the witch much as the Prince rescued Rapunzel. The latter would be impossible since the "witch" of course remains a part-object representation that is also present in the patient's psyche and yet, as in the case of Elaine, often still a real object in the world with which the patient contends.

This horror seeps ever so gradually into the fabric of the analysis. Whereas Elaine felt lifeless, helpless, and guilty, her matricidal anger began early on to emerge in dreams of *Now, voyager* (Wallis & Rapper, 1942), then in the recounting of terrible child abuse stories from the news that kept her awake, and then telling me about her often grueling work for a domestic violence legal aid agency, and the trials of adopting a maltreated cat. Elaine's own murderous and maltreating wishes were at first not possible to contemplate. Elaine knew all too well that rageful feelings and sadistic wishes can quickly turn to real violence – as bottles of steak sauce had become missiles during her childhood.

In my research team's clinical research at the University of Geneva, which extends my previous work at Columbia University in New York, we work with traumatized mothers and young children who have experienced interpersonal violence (Schechter & Rusconi-Serpa, 2014). As Fraiberg et al. (1975) taught us, mothers have transferences to their infants that begin during – and I suggest, even before – pregnancy. If the mother herself has been a participant in a scene of family violence and maltreatment, and has experienced helplessness and fear for her survival, she may also have experienced a major threat to her primary attachment relationship (upon which she depended for survival), and the difficulty of that attachment relationship functioning adaptively in the service of the development of emotion and arousal regulation, as well as of brain development that accompanies these developmental functions.

In infancy and childhood, severe traumatic insults that are chronic and repetitive lead to permanently altered stress reactivity and initiate alternative circuit development to permit the maximal amount of autoregulation in the face of threat and pain, a common result of which is a dissociation of feeling and thought contact, and a disrupted sense of continuity of time, space, and self in time and space. Moriceau and Sullivan (2006) have shown that the infant rat or "pup," during a critical period of development during which he is mortally dependent on the mother rat, will tolerate aversive electric shock as a model of physical abuse in order to maintain contact with mother.

This translational research extends our traditional model of masochism. Relational priorities supersede those of the pleasure principle (Freud, 1920). As Kurt Fischer (Fischer, Ayoub, Noam, Singh, Maraganore, & Raya, 1997) has noted, some apparently illogical, maladaptive behavior is, on second thought, logical and adaptive in response to crazy environments. What can become psychopathology when generalized across situations and periods of human development can begin as an adaptation in a specific situation and during specific developmental periods. Over time, what started as an adaptation with specificity can, if generalized, lead to trouble due to the lack of flexibility of adaptation and of complexity.

The key element of this adaptation in the case of Elaine and perhaps also of her mother, at least through Elaine's eyes, is that of her submitting to her mother's traumatically biased intersubjectivity at the expense of her developing self-regulatory capacities regarding her own affect and arousal. A consequence of this submissive relationship with her mother was that Elaine developed a significant a painful anxiety disorder with panic attacks, and a significant threat to her abilitiy to serve as a mutually regulatory force in her future child's emotional development.

What I did with Elaine in the analysis has, at its foundation, what I also do with the traumatized parents of very young children in the experimental intervention technique that was borne out of our research with violence-exposed families – the Clinician Assisted Videofeedback Exposure Sessions, or "CAVES" (Schechter et al., 2006; Schechter et al., 2015). While clearly Elaine's psychoanalysis did not involve the use of videotaping or videofeedback, the joint focus of attention on Elaine's interactions with her mother and significant others as she represented them in her verbal accounts and her gestures, and that she otherwise, without the presence of the analyst, might have avoided reflecting upon, became an important piece of the treatment.

Elaine's psychotherapy and analysis thus shared in common with the CAVES the following. First was the formation of a therapeutic alliance via focusing on the positive mental representations and interactions (as positive as one can find), consistency of the frame and safety, modeling of reflective functioning and of affect, and arousal labeling and regulation. Second, we looked together in joint attention at dyadic moments involving helplessness and distress that Elaine might otherwise avoid: separation moments when Elaine's terror would have triggered helplessness in her mother and, via the maternal transference, in her analyst. During the CAVES, we repeatedly ask, as if in a mantra that can be easily memorized during

and just after stressful moments: What is going on in your mind? What do you think was going on in her (Elaine's mother's) mind? Third, we looked together at how Elaine's mother reacted to Elaine's distress and anxieties when they came back together, and what made Elaine hide her own competence so much from her mother. Finally, we also looked together at curious moments: What might have made Elaine's mother jump out of the cab in the middle of traffic? How did Elaine feel in response? What made her mother peer at her through a telescope from her terrace?

We find in the treatment of Elaine a lot of what we find in our CAVES sessions, namely that helplessness, fear of separation, and vulnerability are confused with rage and controlling behavior. The witch fears losing her powers and melting with a wake-up splash on the face.

In our own empirical research, we have postulated that mothers who have been traumatized by interpersonal violence may be dysregulated by normative distress in their child, such as that produced during rapprochement in the early part of the second year of life (see Coates, Rosenthal, & Schechter, 2003; Coates, First, & Schechter). This dysregulation on the part of the mother, we have found, often results in projections that identify the child with an aggressor as a defense against seeing the helpless, dependent state of the child. What we have observed is that, although able to engage in following the child's lead and jointly attending to a focus in both the external and internal worlds when not stressed, violently traumatized mothers have difficulty responding to their child's bids for joint attention after separation stress.

Traumatized mothers as such cannot help their children tolerate affects that they themselves cannot tolerate. Much as Fraiberg et al. (1975, p. 396) wrote, "When [the] mother's own cries are heard, she will hear her child's cries." Our research has explored the mechanism behind this observation. We have found that, for some reason, when confronted with child distress, traumatized mothers are not able to engage the higher cortical (or medial prefrontal cortical) regions of their brain, as shown on functional neuroimaging, that are associated with internal regulation of their raw emotional or "limbic" response to their own and unfamiliar child separation distress, and the accessing of autobiographical memory (Schechter et al., 2012; Schechter et al., 2015).

The parents report feeling stressed to the point that, rather than just having trouble hearing, they have trouble seeing their child's facial expressions of fear and helplessness, and they show increased avoidant, withdrawing maternal behavior as well as increased hypervigilance and irritability when playing with their children. In an effort to avoid such affects all together, the very same parent can enhance the child's helpless dependence while having the very best intentions to protect the child from the violent traumatization they themselves suffered. So, even Elaine's mother's "witch-like" behavior may in retrospect have been motivated by her focus on her own survival and self-regulation. This understanding can facilitate the reorganization of maternal identifications that is so important during pregnancy.

Whatever the cause of the perception of mother "as witch," my patient Elaine – and perhaps also de Beauvoir – must hide their maternal side. They must not compete for fear of receiving the poison apple in Snow White. They must not show their separateness or their individuality. We analysts serve as the observing third that helps to detach mother-to-be from mother that never-really-was. The maternal representation, self-representation, and representations of the child, and the relationship with the child *all* change as a result. The solvent to this adhesive involves a healthy dose of active, sensitive confrontation of avoided affects, building up of tolerance, and integration of these affects, including split-off matricidal rage. We as analysts must also bear the challenge of self-doubt, feeling inauthentic, feeling witch-like, and wanting to throw the bucket of water to liquidate the burning envy and hatred that dates back at least to our patient-mother's own infancy, if not to her mother's and to prior generations of traumatized women.

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