MOTHER-BLAMING, RELATIONSHIP PSYCHOPATHOLOGY, AND INFANT MENTAL HEALTH: A COMMENTARY ON WARD, LEE, & LIPPER (2000)

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In this issue, Ward and colleagues (Ward, Lee, & Lipper, 2000) report that infants diagnosed with failure-to-thrive were less likely to be securely attached to their mothers than infants growing normally. Further, they also report that mothers of infants failing to thrive were significantly more likely than mothers of infants growing normally to be classified as Unresolved (with respect to loss or trauma) based on their discourse patterns in the Adult Attachment Interview (AAI; George, Kaplan, & Main, 1984). At the conclusion of their article, they indicate “hesitancy” about reporting their findings lest mothers of FTT infants be “blamed” for their infants’ feeding problems and growth failure. Because there is simply no way to consider blame as a part of the scientific investigative process of attempting to understand how different variables relate to one another, we believe that Ward et al. (2000) are concerned about the clinical implications of their findings, that is, what conclusions will be drawn from them regarding mothers of infants with growth failure. Although mother-blaming is certainly not a new issue in infant mental health (see Chess, 1959, 1964; Korner, 1961, 1968), it is a persistent one. We believe that when a distinguished research group is hesitant about reporting their findings for fear of being perceived as mother-blaming, a reconsideration from the clinical perspective may be indicated.

Mothers, of course, are not the only ones who get blamed—infants or other caregivers may be blamed for a particular problem or behavior. Nevertheless, mothers generally do get the lion’s share of blame. Mothers are blamed in part because of their involvement—they are the ones who are for the most part “in the trenches,” caring for their infants. In fact, Jordan (1997) has pointed out that as a field, infant mental health has minimized gender politics. She has underscored a central irony: in our efforts to avoid mother-blaming by substituting the more neutral terms, “parent” or “caregiver” for “mother,” we do mothers an injustice. Paradoxically, she argues, these neutral terms serve to displace mothers from positions of power,

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influence, and involvement that they deserve, and they minimize gender differences that are both real and important.

In this commentary, we begin by defining blame, suggest reasons why blaming may occur, and underscore the clinical value of understanding it.

According to the Oxford English Dictionary, blame is defined as “to find fault with, to censure,” and is derived from the Latin, blasphemare, “to revile, reproach.” No one would argue that finding fault, censuring, reviling, or reproaching are part of the clinical process of attempting to ameliorate problems. Nevertheless, fault-finding is a time-honored human pastime, so blaming does occur, especially when we consider questions such as: What causes psychopathology in infancy? How do we conceptualize psychopathology in infancy?

In recent years, an explicitly relational approach to understanding psychopathology in infancy has been advocated. Although other models exist, to be sure, but we believe that the relational approach has dominated the field for more than a decade. A relationship perspective assumes that infant–parent relationships comprise interactional and representational components in both infants and parents (Stern, 1995; Stern-Bruschweiler & Stern, 1989). Assessment and treatment are most likely to be effective when all of these components of the relationship are included (Stern, 1995; Zeanah, Larrieu, Valliere, & Heller, 2000). This means focusing on both overt interactional behaviors as well as on the meaning of those behaviors. Most psychopathology in the early years, though often expressed as child symptomatology, may be conceptualized more usefully as relational (Anders, 1989; Lyons-Ruth, Zeanah & Benoit, 1996; Sameroff & Emde, 1989; Stroufe, 1989b). Risk factors for psychopathology (as well as protective factors) may derive from the infant, the caregiver, or the unique fit between them.

There is simply no place for blame in this model. Risk factors in parents and infants are differentially activated, depending upon a host of contextual variables and complex interactions that we rarely understand. One of the most important contexts is culture, as wide differences in parenting practices may be supported by different belief systems (Garcia-Coll & Meyer, 1993). Furthermore, there is variability also in how risk factors express their influence. Our best scientific methods deal only with probabilities and not with absolutes. In a relational model, causality never is simple, linear, or unidirectional. And, if we are honest, we will acknowledge that in clinical work as in research, the largest amount of the variance in outcomes usually is unexplained. The humility inherent in this fact alone should be a sufficient antidote for the urge to blame.

And yet, clinicians must be able to discover, acknowledge, and attempt to understand all sorts of problematic parental behaviors. Parents are sometimes cruel, insensitive, and/or harmful to their children. Clinicians face these and other parental shortcomings routinely, and must work with and through them. The contextual approach to relationship psychopathology that characterizes infant mental health encourages understanding the roots of parental, as well as infant, behavior. A true strengths approach requires not ignoring weaknesses, but rather facing and transcending them (Zeanah, 1998). Problematic parenting practices or attitudes in mothers or other caregivers cannot be ignored—nor should they be used to attempt to explain what we do not understand.

We suggest that the urge to blame and the act of blaming are important indicators of countertransference, and as such, they have potential value for infant mental health professionals. We are defining countertransference as feelings in the clinician elicited by the infant and/or caregiver that threaten the therapeutic alliance by motivating the clinician to behave deleteriously to the best interest of the infant and caregiver. In this model, countertransference feelings in the clinician may or may not lead to counterproductive behavior. In the examples below, we use the term, “mother,” in keeping with the theme of “mother-blaming,” although we reiterate that either parent or other caregivers may be blamed also.
Often, the clinician displaces onto the mother the clinician’s own unconscious negative feelings about the infant, the mother, the infant’s relationship with the mother, or other contextual features of the infant’s symptomatology. Some individuals often elicit negative reactions in others, but countertransference always includes some aspect of the clinician’s unresolved/conflicted life experiences and relationships, as well. One common form of countertransference is to blame the mother for the clinician’s own unacknowledged painful feelings deriving from identification with similar vulnerabilities or circumstances displayed by the infant. By over-identifying with the infant, the clinician may feel critical towards the mother. Without awareness, the clinician then may repeat early relationships experiences by lashing out at perceived unfair or unkind maternal behavior. Rather than accepting responsibility for his/her own re-awakened feelings of rejection, shame, or helplessness that are engendered by the infant’s condition, the clinician blames the mother.

In another pattern, the clinician may overidentify with a mother’s despair and disenfranchisement by feeling incapable of assisting the infant, understanding the mother, or recognizing the context in which the symptoms emerged. Feelings of impotence may be displaced onto the mother in the form of blame or derision. In this pattern, the mother may feel blamed, and she may discontinue the treatment, thus absolving the clinician of responsibility for helping the infant and mother, as well as alleviate the actual source of discomfort, that is, his/her perceived inability to provide the necessary assistance.

Another way in which “blaming” countertransference can be manifest is the clinician distancing him/herself by deriding selected characteristics of the mother (e.g., through labels such as “poor,” “underachieving,” “unmotivated,” or “untreatable”). Once attributed to mothers, these labels can be used both to explain the infant’s symptomatology and to reassure clinicians that these characteristics are quite different from their own.

A clinician who feels insecure or inadequate may become competitive with a mother in an attempt to win the infant’s affection, or just to appear competent in the caregiving role. How a clinician interacts with an infant in front of the infant’s mother is always challenging. In a conscious effort to model “appropriate” parental behavior, the clinician actually may be blaming the mother implicitly for not appreciating the infant’s special qualities or for being unable to respond to the infant competently. In a related, well-recognized pattern, clinicians may ignore positive and effective aspects of mothers’ behaviors, focusing on deficits rather than strengths, adding blame to lowered expectations. Clinicians also may be drawn into recapitulating the mother’s own early relationship experiences with a critical and punitive parent by enacting the role of the latter.

Clearly, all of these examples of acting out unconscious conflicts by the clinician run counter to effective intervention with infants and families. Still, these are all common feelings in clinicians who work regularly with infants and toddlers and their caregivers. What is important, we believe, is how the clinician responds once feelings of blame are elicited. If the clinician can restrain from acting on the feelings, but seeks instead to understand their source and derivatives, then the feelings actually may be used constructively in a variety of different ways (Seligman, 1993). Thus, in our view, clinicians who find the urge to blame replacing the urge to understand, must recognize that an important interpersonal transaction is occurring. The goal of clinical work is not to avoid negative feelings like blame, but rather to understand them.

To return to where we began, mothers of FTT infants in the Ward et al. (2000) study had AAI classifications that were more likely to be insecure than secure. If we assume that the association between mothers’ AAI classifications and infants’ FTT is true, then the question becomes, what do we make of this? There is reason to believe from both the clinical and research perspectives that adult attachment classifications describe differences in the organi-
zation of how these mothers remember their own experiences in childhood and how they experience their infants subjectively (Hesse, 1999; Zeanah, 1993; Zeanah, Finley-Belgrad, & Benoit, 1997). Both memories of their own childhoods and their subjective experiences of their infants, represent important potential targets of intervention with mothers. Exploring these areas provides rich opportunities for mothers to gain insight into their intimate relationships and to enhance the development of their infants. On the clinician side, thoughtful exploration of this material also provides opportunities for becoming more aware of unexamined or unresolved feelings, needs, or conflicts that may be expressed as blame. In this way, clinicians’ effectiveness with mothers and infants may be enhanced rather than impeded.

REFERENCES