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**Representational Content and Quality
of Mothers Whose Children are Failing to Thrive:
A Rorschach Study Linking
Inner Life with Interpersonal Behavior**

by
Catherine E. Monk

**A dissertation submitted to the Graduate Faculty in Psychology in partial
fulfillment of the requirements for the degree of Doctor of Philosophy,
The City University of New York**

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This manuscript has been read and accepted for the Graduate Faculty in Clinical Psychology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

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Abstract

**Representational Content and Quality
of Mothers Whose Children are Failing to Thrive:
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by
Catherine E. Monk

Adviser: Dr. Steven J. Ellman

This study carries forward the exploration of a link between internal object representations and interpersonal experiences. Attachment and psychoanalytic ideas concerning the significance of unconscious relationship templates and symbolization capacities for the quality of interactions were used for insight into children's development of failure to thrive (FTT). Subjects were 52 mothers and their 9- to 24-month-old child; 28 of the children were normally growing and 24 were FTT. All dyads were video taped for 10–minutes of free play and an unspecified time for feeding. The interactions of the dyads were then coded using Crittenden's (1983) CARE system, which assesses maternal sensitivity, and Chatoor's (Chatoor, Menvielle, Getson, & O'Donnell, 1988) index of the level of reciprocity versus conflict in the dyadic interaction. Mothers were later administered the Rorschach which was coded using the Mutuality of Autonomy Scale (Urist, 1977) and the Transitional Object Scale (Greenberg, Craig, Seidman, Cooper, & Teele, 1985).

Mothers of FTT children had less varied, more uniform representations of self and other, which, in general, were void of aggressive interactions, while mothers of normally growing children had access to a wide range of represen-

tations, which included non-mutual, domineering experiences. Mothers of FTT children were judged to be less sensitive during free play and to have more conflicted feeding interactions. The specific kind of internal representations which differentiated the mothers by group were not associated with the group differences on behavioral interactions, which suggests an unidentified conduit for the significance to FTT of mothers' uniform internal representations. However, there was some evidence for relations between mothers' capacities to represent and access a wide variety of internal representations as well as to symbolize in ways reflective of flexible movement between subjective and objective perspectives and the level of mutuality in interactions.

The results of the study support the need to pay attention to the emotional quality of the dyadic relationship in the conceptualization and treatment of FTT as well as uphold the attachment and psychoanalytic notions of the importance of the unconscious inner world to the shaping of interpersonal relationships, particularly those between a mother and child.

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In memory of C. A., April 20, 1943 — March 25, 1997; not in content but in gesture.

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Chapter 1: FTT: A Review of the Literature

Introduction

Children who have access to adequate amounts of food yet fail to reach or maintain appropriate weight levels are diagnosed as Failure to Thrive (FTT). Infants in the first few months of life as well as toddlers and preschoolers can develop FTT. At times their starvation becomes so serious it warrants hospitalization. Specifically, FTT is diagnosed when full-term infants experience growth delay that places them below the fifth percentile for normal growth curves or they are older than six months and experience deceleration in weight gain that is sufficient to bring their weight below the tenth percentile, after passing two major percentile markers within a sixth month period (i.e., weight-for-age decreases of two or more standard deviations on National Center for Health Statistics growth charts (Ward, Lipper, & Polan, 1991)). Incidence reports of FTT range from five percent of all pediatric hospital admissions to 10 percent of rural child outpatient admissions and up to 15 to 30 percent of children's admissions to urban emergency rooms (Breunlin, Desai, Stone, & Swilley, 1983; Frank & Zeisel, 1988). FTT is found across racial and socio-economic groups (Ward et al., 1991).

Follow-up studies of FTT children suggest they experience long-term cognitive, emotional, and physical problems presumed to be associated with their early feeding disorder. FTT children who were hospitalized at an average age of 4.9 months showed a decline in their cognitive development at 36 months (Drotar & Sturm, 1988). FTT children who had extended hospitalizations in infancy (at 5.4 months), at 3 years had persistent intellectual delays and chronic health problems despite gaining weight during their hospital

stays (Singer, 1986). As preschoolers, children who had had FTT demonstrated deficits in behavioral organization and parents of FTT children also identify higher levels of behavioral symptoms in their FTT offspring than do parents of normally growing control children (Drotar & Sturm, 1992). In general, FTT children show cognitive deficits, behavioral problems, and learning difficulties throughout their academic years (Phelps, 1991) and are believed to be at an increased risk for behavioral and emotional problems (Black & Dubowitz, 1991). A study examining the histories of abused children ages five to ten found a significant number of them had had FTT in their early years, an association between FTT and physical abuse that suggests many FTT children may suffer abuse in their futures (Famularo, Fenton, & Kinscherff, 1992).

This review of the literature will briefly cover the history of FTT from its conceptualization as a primarily psychological disorder rooted in the mother-child relationship to the present-day bifurcation of perspectives used to study it—a split between a biological-behavioral approach versus one that includes psychological factors in the understanding of FTT's etiology. A dramatic shift in the theoretical orientation of American psychiatry will be linked to both the current split in approaches to FTT as well as a jettisoning of explanatory models in most of the remaining psychological approaches. The attachment paradigm will be discussed as one of the few perspectives that offers a psychologically informed, explanatory model, which considers the contribution of the mother's emotional functioning as well as the mother-child relationship to the etiology of FTT. Specifically, this research has found mothers of FTT children are most often classified as insecurely attached. It is hypothesized that these mothers' insecure representations of attachment may produce a disordered relationship, which, in turn may contribute to a serious feeding problem (Benoit, Zeanah, Barton, 1989). The present study will be described as

an attempt to broaden the understanding of FTT by further delineating the quality of mothers' internal representations and linking them with the mothers' behavioral interactions with their child and the child's FTT status. A psychoanalytic perspective on object representations will be discussed as adding to the research by providing an expanded view of internal representations and their function in interpersonal behavior. A brief summary of the literature review, statement of the research problem, and general hypotheses conclude the chapter.

History of FTT

In May of 1908 when Dr. Chapin of New York City met his American Pediatric Society Colleagues at the Delaware River Gap and offered them a "plan of dealing with atrophic (or FTT) infants and children," he advocated putting each child in foster care with his or her own surrogate mother rather than placing them in institutions where "the vast majority of the(m) will die, no matter how carefully they are nursed and fed" (Chapin, 1908, p. 817). Although these children, "poor little waifs" as he called them, were living in poverty, he blamed the "deficient and inefficient fathers and mothers" for their nutritional status. He not only considered the parent-child interaction as a factor in FTT, but hinted at the role of an individualized child-caregiver relationship for improving the child's physical health.

Turn of the century pediatricians who were treating infants who were refusing to eat—that is, infants with anorexia nervosa (Forchheimer, 1907; Griffith, 1908)—also focused on the parent-child relationship. Only as recently as the previous fifty years had anorexia been named and discussed in the medical literature (Silverman, 1989; Vandereycken & Van Doth, 1989) so

that in 1907 Forchheimer could claim he was treating the first infant case, G.W., a 12-month-old male infant whose mother, father, and family “were all neurotic”. G.W. had eight teeth, weighed 25 pounds and had never been ill in any way. When at nine months other foods were introduced, he refused. At 12 months he was removed from his mother in order to be weaned. For two weeks he rejected everything except water; he was force fed. Slowly, he began to eat and after three weeks he ate enough on his own and was gaining weight. Another early case, Morton G., studied by Griffith (1908), had been ill and given medicine orally at nine months. Afterward he willingly breast fed and ate bread from his own hand but wouldn’t take anything given to him from a spoon or glass, as the medicine had been given to him. By 20 months weaning was deemed imperative. Morton G. was then force fed for six months. According to Griffith, this was an incidence of “nervous anorexia,” as there was no evidence of organic cause, except perhaps “the giving of medicine ... (which) awakened a fear of anything which was put into a spoon” (Griffith, 1908, p. 322). Forchheimer warned that “the pure scientist should keep his hands off these cases” because he “spoils them for future treatment by others who understand the art,” which he thought consisted of treating the mental state, the essence of the condition (Forchheimer, 1907, p. 808).

Other terms in addition to atrophic infants and anorexia nervosa were also previously used for FTT: emotional deprivation (Bakwin, 1949), sensory deprivation (Casler, 1961), psychological malnutrition (Talbot, 1963), maternal deprivation (Bowlby, 1952; Patton & Gardner, 1963), environmental failure to thrive (Barbero & Shaheen, 1967), environmental developmental retardation (Coleman & Provence, 1957), deprivation dwarfism (Gardner, 1972), and psychosocial dwarfism (Hopwood & Becker, 1979; Powell, Brasel, & Blizzard, 1967; Reinhart & Drash, 1969; Silver & Finkelstein, 1967). Each of these terms

referred to a hypothesized etiology of a disruption in the emotional interaction of the mother and child leading to FTT. While at times the focus seems to have been on 'deficits in mothering'—as opposed to on the dyad as a mismatch and/or as bi-directionally negatively affecting each other—the perspective was predominantly psychological. Specifically, deficits in mothering were thought to take one of four forms: child institutionalization; separation from a mother; multiple mothering in which there is no one continuous person performing the major caregiving functions; and distortions in the quality of mothering such as rejection, overprotection, and ambivalence (Yarrow, 1961).

To further examine the role of the mother-child relationship in FTT, Spitz (1945) compared infants in a nursery with infants in a foundling home and found that the *physical health* of the foundling home infants was compromised. Since children in the nurseries had their mothers or mother surrogates tending almost exclusively to them while the foundling home children were cared for in a ratio of one caregiver for eight infants, Spitz concluded that despite adequate nutrition, these children "suffer because their perceptual world is emptied of human partners" (Spitz, 1945, p. 68). Widdowson (1951) replicated Spitz's findings, showing that satisfactory caloric provision in an unfavorable *psychological* environment was insufficient to sustain adequate growth.

Elmer's 1960 paper, *FTT: The Role of the Mother*, argued that the social environment is crucial to treating FTT children. To her, a good physician "intuitively senses the importance of the mother's feelings about rearing her infant, and he treats the mother and child as a single unit" (1960, p. 725). Winnicott (1936) believed that when a child suffered from a physical condition such as vomiting or anorexia, the illness could not be fully explained

without reference to the child's psychic experience, in particular without reference to the child's relationship to their mother.

An article titled *The Significance of the 'Emotional Climate' in Early Feeding Difficulties* demonstrated through two case presentations how "a mother's own conflicts and anxieties may be re-enacted in her child's development with a remarkable similarity" and contribute to the child's eating problems (Rank, Putnam, & Rochlin, 1948). In one case, Lilly, a girl of 4, is described as tense and nervous. She "has no appetite, had been difficult with her feeding, and vomited a great deal since birth" (Rank et al., 1948, p. 281). Lilly's mother, who often suffered from somatic symptoms such as anorexia and vomiting, was full of hatred centered on her own father and herself. She felt "inferior, ugly, and unlovable" (Rank et al., 1948, p. 281). When Lilly was born, she refused to even look at her for days. She did not breast feed her, reporting later "it was horrifying to think of being food for someone, of taking someone in the mouth" (Rank et al., 1948, p. 281). The authors' hypothesized Lilly's food refusal as a reaction to her mother's unconscious hostility. Sensing her mother's rage towards her, Lilly had phantasies¹ about being eaten up and, in response, developed cannibalistic phantasies herself and vomited and refused food as a defense against them.

In the second case, a three-and-a-half-year-old girl was brought to treatment due to "extreme and increasing temper tantrums, destructiveness, fears, and nightmares which her mother immediately ascribed to her own prolonged conflict with Betty over food" (Rank et al., 1948, p. 279). Since she was 9-months-old, Betty had been on a highly restrictive diet due to celiac dis-

¹Following Isaacs (1952), this text will use the spelling *phantasy* to connote "the primary content of unconscious mental processes" as opposed to *fantasy* referring to conscious daydreams and fictions.

ease. This diet seems to have initiated a struggle between mother and child; the child often felt deprived and tried to sneak food. The mother would alternatively enforce the food restrictions over-zealously or give in abruptly, which would cause Betty to gorge and ultimately get sick. While a rigid diet is hard for any mother and child to manage, it proved to be pathogenic for Betty and her mother in part due to Betty's mother's history and resulting emotional conflicts around abundance and deprivation. Betty's mother had grown up in emotionally and financially bleak circumstances. Remembering her own starvation, she said "refusing a child begging for food is the worst thing possible" (Rank et al., 1948, p. 280). Betty's mother managed her intensified neediness and rage based on deprivation (which induced a fear of retaliation) by a "masochistic" defense; she became disinterested in food and overly compliant towards her mother and in general, self-effacing. When feeling under pressure, she suffered from physical symptoms in the gastrointestinal tract, such as nausea, indigestion with abdominal cramps, and diarrhea. The authors see Betty as finding a similar solution: "Betty ... take[s] refuge in obsessive personality traits in order to become finally the outwardly good, obedient girl, very dependent on mother. The masochistic element prevails" (Rank et al., 1948, p. 282).

Novick and Novick (1987) saw FTT as a bodily response to a mother's emotional withdrawal and as the result of dissynchrony between mother and child. They wrote:

In films of feeding before 4-months, Nicole attempted to engage her mother in social interactions between bites. After each bite, Nicole's mother literally scraped the smile off Nicole's face with the spoon, until the sixth bite was followed by a frown. This is a good example of ... the failure to repair a mismatch between mother and baby. In our observation we could see the next step, in which the mother externalized her feelings of failure onto the

baby: the mother made it clear that she found Nicole an unpleasant girl. Soon thereafter the mother's depression coincided with Nicole's failure to thrive (Novick and Novick, 1987, p. 356).

While Nicole began to gain weight after clinical interventions, the Novicks observed that the effect of sustained dissynchrony persisted. Like other children of depressed mothers, Nicole moved away from signaling for her mother. Instead, similar to children who try to self-soothe through rocking and withdrawal, she began to pull her hair. For many months, a spot on her head was nearly bald. The Novicks understood Nicole's hair pulling as an example of a pain-seeking behavior—and her initial FTT symptoms as a precursor to this pain seeking behavior, both of which were adaptations to a pathological situation. For Nicole, safety resided in an object (her mother) that induced pain rather than pleasure; to evoke the experience of the object and tolerate the object's uninvolvedness, Nicole reproduced an experience that called forth the object's presence.

Fraiberg and her colleagues described several cases of FTT in which the unpacking and working through of the mother's emotional conflicts was the key to helping the child recover.

Nina, as described by Fraiberg, was born to a 16-year-old young woman named Karen, and hospitalized for FTT when she was 7-months-old. The therapists noted that although the signs of human attachment were present in Nina, her mood was somber and her vocalizations were sparse and undifferentiated. Karen, who came from an unloving home in which she took on a passive resignation to her experience of never measuring up, defended massively against any experience of affect. Many sad, helpless, and angry feelings were not symbolized but instead expressed as somatic symptoms and she had been anorexic for years (Fraiberg, 1995). A key question became "If Karen

can't read the signs of hunger in herself, how could she read the signs of hunger in her child?" According to the authors

Karen's anorexia was the key to Nina's own deteriorating nutritional and psychological status, but the internal conflicts of this adolescent mother which were represented in anorexia and depression were not at this time accessible to treatment. Each of the therapist's attempts to elicit affect led to denial, blankness, and we read them as 'fear of loss of control,' the ego's anticipation that if inner rage and grief should be liberated they would engulf the personality ..." (Fraiberg, 1995, p. 115).

Through supportive treatment which gave Karen a place to unburden herself as well as experience a different model of caring, Karen and Nina became much healthier. To help Karen become a more sensitive mother who could respond well to her daughter's needs, therapists had to help Karen overcome the conflicts that blocked her access to empathy and neediness. Since this couldn't be done directly, they used her daughter to help her find a safe way to gain access to her own inner emotional life. Specifically, focusing on Nina and understanding the way events affected her behavior was the one way in which Karen could experience the relationship between her early experience and feelings and her present feelings and difficulties; her more defended feelings were thus dealt with through her identification with her daughter.

In other clinical examples specifically focusing on FTT, Fraiberg and her colleagues describe a similar pattern of mothers' lack of synchrony with their babies, feelings of rejection and hurt when the child doesn't eat, and states of being profoundly shut-down to their own affective experiences—a massive constriction that interferes with their ability to care for their children. For example, when one mother finally re-experiences the rage toward a younger sibling, she can more spontaneously turn towards her child with affection.

With the rage accessed and connected with its rightful recipient, the sister of rivalry, this mother can turn toward her child with love. Previously, she had tended to act out a sadistic game with her baby, viewing him as competitor rather than as someone dependent on her (Fraiberg, 1995). Another mother could see the similarities between herself and her baby, both being unwanted and unloved, but on her own she couldn't make the affective links that would begin to enable her to respond empathically to her FTT child (Fraiberg, 1995). Without access to what it felt like to be uncared for, this mother seemingly easily tolerated seeing her child's early life mirror her own.

In these reports, Fraiberg explicitly emphasizes parents' denial of affect and use of other defenses such as identification with the aggressor as useful concepts in understanding parents of FTT children who are unable to *not* inflict their childhood pain upon their own child. However, her clinical material also suggests that "the quality of the mental representation of the object and the representation of the self's relationship to it may be a further important determinant" (Fonagy, Steele, Moran, Steele, & Higgitt, 1993, p. 959).

Up until the late 1970's, FTT was largely conceptualized as an intrapsychic and interpersonal problem of the mother-child dyad. In particular, the mother's psychological functioning, her character structure and unconscious conflicts, were related to her behavior with the her child and understood to be important ingredients in her child's failing to thrive. However, nearly two decades after Spitz' and Widdowson's research and numerous clinical cases demonstrated the significance of the emotional environment in FTT, other researchers disputed this thesis and with it, a psychological perspective on FTT.

In 1969, Whitten and his colleagues argued that infants were underweight because of under-eating which was secondary to not being offered adequate

food or not accepting it (Whitten, Petit, & Fischhoff, 1969). They presented data to show that 11 of 13 maternally deprived infants gained weight at an accelerated rate when fed adequately while living in a hospital environment that simulated their sensory-deprived home environment. Furthermore, seven of seven deprived infants gained rapidly in their homes when their mother fed them enough food in the presence of a "neutral" observer. While Whitten and his co-workers were marshaling evidence against a specific hypothesis of FTT as resulting from a psychologically induced deficit in nutrient absorption and physiological metabolism, their research was used to argue that a sufficient caloric intake may be enough to promote recovery in a FTT child *regardless of changes in the emotional climate of the dyad*. Their work inadvertently supported one side of a crystallizing debate: whether FTT is better understood as primarily a psychological problem of the mother-and-child interaction or as an organic, medical one of substandard nutrition.

The Spitz-Widdowson vs. Whitten debate typifies American psychiatry's dramatic shift away from a psychosocial perspective which considers psychological etiology in tandem with bodily functioning. In its place came a return to Kraepelin's 19th century descriptive psychiatry, a medical model approach concerned with the delineation of biologically based disease.

Briefly, the transformation in American psychiatry that is the background for the changing view on FTT is, according to psychiatrist Wilson, as follows: "From the end of World War II until the mid-1970s, a broadly conceived biopsychosocial model, informed by psychoanalysis, sociological thinking, and biological knowledge, was the organizing model for American psychiatry" (1993, p. 399). Menninger's famous question "what is behind the symptom?" epitomized this psychiatric orientation. Clinicians sought to understand the meaning of the symptom (how it resulted from the suffering indi-

vidual's attempts to adapt to his or her environment) and "to undo its psychogenic cause (rather than manipulate the symptom directly through medication, etc.)" (Wilson, 1993, p. 400).

With the shift away from a psychosocial approach, psychiatrists focused on generating and re-fining a labeling language that enhanced their capacities to accurately name what they see and conduct epidemiological studies. The content of clinical concern narrowed to exclude character, unconscious conflict, transference, and family dynamics. The consideration of time shrank from a developmental perspective on a lifetime to what happened in the past several weeks and a careful description of symptoms became the standard for a proper patient assessment. (Wilson, 1993).

The replacement of the term 'FTT' for the formerly used ones reflects the new descriptive, disease model approach to the disorder. In 1899 when the term FTT first appeared in the literature, it was used for growth problems due to specific *organic* causes, such as idiopathic hypercalcemia (Holt & McIntosh, 1933). As recently as 1952 the term was primarily reserved for this purpose. Then the name FTT began to include children losing weight without a known organic cause (those who had, for example, what was called maternal deprivation) and it was divided into Non-Organic Failure to Thrive (NOFTT) and Organic Failure to Thrive (OFTT). However, in 1981, Homer and Ludwig questioned this distinction as 23% of their sample could not be categorized as exclusively having organic or non-organic FTT (Homer & Ludwig, 1981). Consequently, current researchers define FTT as a syndrome of malnutrition associated with a heterogeneous group of both biological and psychosocial problems (Frank & Zeisel, 1988; Woolston, 1985) but they use the name historically associated with a biologically-based, disease syndrome. Important here is the subsumption of all the former names for FTT sugges-

tive of the potential contribution of mother–child interaction (e.g., maternal deprivation) under the medical term "FTT" so that instances in which psychological factors are salient are now known by the medical term. Much of the psychological inquiring about FTT has been lost as the psychosocial paradigm has been largely left behind. While the idea of maternal deprivation placed almost exclusive emphasis on mothers' emotional problems, somewhat neglecting the mother and child interaction as well as the child's biological vulnerabilities and contribution, most of the contemporary approaches either omit psychological factors altogether or rely on conscious and observable assessments at the expense of investigating underlying personality factors and conflicts potentially contributing to FTT. Few any longer ask 'What is behind FTT?'

Two Contemporary Perspectives on FTT

The Medical approach:

Most pediatricians and psychiatrists approach FTT as primarily organic in origin (a physical defect in the infant resulting in inadequate nutrition) or as a behavioral problem of poor parental feeding technique which, through inadvertent positive and negative feedback, has led to an entrenched feeding routine that leaves the child lacking sufficient food. For example, Ramsay and her colleagues propose that *non-organic* FTT (the version of the disorder appearing without an obvious organic cause) is, in fact, a growth failure that is secondary to a feeding–skills disorder, and that this disorder is neurophysiological in origin (Ramsay, Gisel, & Boutry, 1993). In their study, feeding and mother–child interaction data from 38 infants aged 1 to 31 months suggested an oral sensorimotor impairment that is hypothesized to be present from

birth but tends to go unrecognized. Other researchers have found abnormal oral-motor development in FTT children that is presumed to make them less able to have successful feeding experiences (Mathisen, Skuse, Wolke, & Reilly, 1989). Researchers and clinicians using this paradigm consider psychosocial factors most often only as possible "complicating" variables of growth failure or as a result of the organically based disorder (e.g., mothers and children have misattuned feeding interactions because the child cannot properly eat). Absent is a search for the elusive 'emotional climate' within a mother and between her and her child that might play a role in the child's developing FTT. The prominent pediatric journal *Contemporary Pediatrics* recently proclaimed "as myth No. 1" the hypothesis that "FTT is an emotional disorder" (Frank, Silva, & Needlman, 1993).

Current treatment of the disorder tends to reflect the medical approach and to disregard potential psychological factors contributing to FTT. Family home services, early compensatory education (Phelps, 1991), developmental stimulation, tactile oral stimulation, contingent social responsiveness, and auditory stimulation during tube feedings (Ramsay & Zelazo, 1988) as well as behavior modification (Bithoney, McJunkin, Michalek, Snyder et al., 1991) are considered to be the state-of-the-art treatment modalities. Specifically, one behavior modification feeding program was designed to eliminate maladaptive feeding patterns. It uses music to mask the introduction of feeding time and 'time outs' to eliminate food refusal and prevent mother-infant interactions that may be maintaining the feeding problem (Larson, Ayllon, & Barrett, 1987). Multidisciplinary teams, deemed crucial in helping the FTT child, usually include a pediatrician, a child psychiatrist, a nutritionist, a nurse clinician, and a social worker (Bithoney, McJunkin, Michalek, Egan et al., 1989). Omitted is a professional to treat the mother's psychological health

and the emotional functioning of the mother–child dyad. (Haynes–Seman and Hart’s (1987) call for a “therapeutic process [that] would provide the vehicle for the mother to deal with conflicts, thus freeing her to respond more appropriately to her infant,” (p. 11) is a notable exception.)

The psychological approach:

On the other side of the split are psychologists who maintain a psychological perspective when exploring FTT. Unlike their medical colleagues, these researchers hypothesize FTT to be a result of “physical, psychological, and interpersonal systems and their interactions,” a view that is consistent with the rejection of the NOFTT and OFTT distinction (Wittenberg, 1990). Under this paradigm, characteristics of the mothers of FTT children, of the children, and of the two of them together have been examined as well as the familial context in which these children develop. This work amounts to considerable data in support of the view advocating inclusion of psychological factors in the understanding of FTT. However, as most of this work relies on self report and observational measures, it too bears the stamp of psychiatry’s recent shift towards description and ‘disease’ delineation.

One study found that 10 out of 12 mothers of FTT children had a sufficient number of the following characteristics to be diagnosed as character disordered: (a) disturbed early childhood histories, (b) poor performance in current day to day activities, (c) behavior or initial contact indicative of fairly severe psychopathology, (d) desire for an anaclitic relationship with an intense need to be taken care of, (e) literal, concrete thinking patterns, with a limited capacity for abstraction or planning for the future, (f) the use of denial, isolation, and projection as major mechanisms of defense, and (g) a predisposition to-

ward action or acting out as opposed to thought (Fischhoff, Whitten, & Petit, 1971). A large-scale research project found that affective disorders, personality disorders, and the co-occurrence in a mother of these two types of disorders existed at higher rates in mothers of FTT children than in mothers of controls (Polan, Kaplan, et al., 1991) while another sample assessed increased levels of clinical depression and severe anxiety in mothers of FTT children (Raynor & Rudolf, 1996). Finally, a case report linked Residual Attention Deficit Disorder in the mother to her two-month-old's failing to thrive; successful treatment with Ritalin reportedly led to significant improvement in the mother-child interaction and the child's growth problem (Daly & Fritsch, 1995).

Mothers of FTT children compared to mothers of thriving infants report more caregiver instability and crises during their own childhoods, respond to self-report questionnaires in ways that reveal them to be experiencing more negative stress in their lives, and lack positive social networks (Gorman, Leifer, & Grossman, 1993). One study found mothers of FTT children had a significantly higher history of abuse (80%) when compared with control mothers (Weston et al., 1993). In general, FTT mothers report more having more negative perceptions of their children (Gorman et al., 1993). In a voice study of mothers of FTT infants and mothers of healthy infants describing their children (with the content filtered out), mothers of FTT children showed less positive affect than the control mothers (Liggon et al., 1992). Mothers describe their FTT children as more taxing, less adaptable, more inconsolable, and more unhappy than control mothers describe their healthy children (Singer, Song, Hill, & Jaffe, 1990).

Children who are failing to thrive show less positive affect during feeding and non-feeding situations with their mothers as well as more negative affect during feeding compared to thriving children (Polan, Leon, et al., 1991).

They also display more negative affect during cognitive, task oriented interactions (Abramson, 1991). During observations with their mothers and interactions with testers, FTT toddlers also were found to be fussy, demanding, and unsociable (Wolke, Skuse, & Mathisen, 1990). Other studies found FTT children to be temperamentally more difficult than the comparison control children, less adept at signaling their needs during mealtimes (Mathisen et al., 1989), and highly reactive to visual and auditory stimuli (Bithoney & Newberger, 1987).

When playing with their FTT toddlers, mothers express more negative emotion than mothers of thriving toddlers (Wolke et al., 1990). Observed with their 6-month-old failing-to-thrive children, mothers have less adaptive social interactional behavior, less positive affective behavior, and end feedings more arbitrarily compared to other mothers observed with their healthy children (Drotar et al., 1990). In particular, studies of feeding have been shown to discriminate different interactional styles between FTT and control dyads. Studies of feeding interactions have found FTT mothers to be more hostile, intrusive, and less flexible (Hutcheson, Black, & Starr, 1993), to feed their children in inappropriate positions, give them too many distractions (Mathisen et al., 1989) and to be less sensitive to cues (Lobo, Barnard, & Coombs, 1992). A feeding scale developed by Chatoor and her colleagues has been shown to reliably discriminate between the dyadic feeding interaction of failing-to-thrive infants and their mothers and control infants and their mothers (Chatoor, Menvielle, et al., 1988; Chatoor, Egan, Getson, Menvielle, & O'Donnell, 1988). This scale has five overall factors by which to measure patterns of mother and child behavior during feeding: (1) dyadic reciprocity, (2) maternal noncontingency, (3) dyadic conflict, (4) bargaining for food, and (5) struggle for control. Chatoor reports that while the control group shows

better dyadic reciprocity, the interactions of the feeding–disturbed group are characterized by heightened levels of conflict, struggle for control, and maternal non–contingency (Chatoor, 1989). Chatoor notes that the most salient differentiating quality between the control and feeding–disturbed group is the mothers' lack of mirroring and seeming inability to read and respond to their infants' cues (Chatoor, 1989).

The family context of FTT children is less cohesive (Drotar & Eckerle, 1989) and less supportive of mothers compared to control families (Benoit et al., 1989). At best, mothers report their relationships with their partners to be less satisfying than mothers with healthy children describe theirs to be (Benoit, et al., 1989), while other FTT mothers have extremely distressed interpersonal familial relationships and even experience domestic violence (Crittenden, 1987). Mothers of FTT children also describe their neighborhoods as more dangerous (Kotelchuck & Newberger, 1983).

This contemporary research offers robust findings in support of including psychological factors in a conceptualization of FTT. Relying primarily on self-report and observational measures, it provides *descriptive* differences of FTT versus control populations. True to Kraepelin's model, this approach produces lists of quantifiable variables which can be understood as predisposing factors to and associated features of FTT; such an approach is useful for the careful delineation of this disorder. However, for the most part, unlike clinical case studies and investigations from different eras, this research does not attempt to offer explanatory models nor discover factors that are thought to 'lie behind' behavior and self reported experience. As Fonagy (Fonagy et al., 1993) puts it

[E]pidemiology cannot explain this probabilistic relationship [between problems in parents' histories and lives and behavior problems in their children] nor can it identify in a clinically (as

opposed to statistically) significant way parents who will be able to interrupt the cycle of deprivation and ensure that their children benefit from a secure environment (p. 958).

In order to move beyond epidemiology and descriptive work, Fonagy suggests systematically studying parents' representational worlds as a way to explore the influence of their psychological make-up on their children's developmental process (Fonagy et al., 1993). Recalling the internalized representations of self and other evident in Fraiberg's clinical case reports of FTT, he sees the examination of maternal representations as a useful approach for the development of explanatory models for FTT. One very successful approach to studying people's inner representational words is the attachment paradigm (Ainsworth, Blehar, Waters, & Wall, 1978; Main, Kaplan, & Cassidy, 1985), which has produced important results concerning FTT.

The attachment paradigm:

Bowlby's (1969, 1973, 1980) focus on separation and loss in children lead him to formulate the concepts of 'mother-infant attachment' and 'internal working models of attachment'. A psychoanalyst influenced by ethology, Bowlby asserted that the need to be attached is a distinct motivational system comparable to mating and feeding behaviors. As Bretherton (1987) describes Bowlby's model the

attachment system refers to a regulatory system hypothesized to exist within a person ... The system's set-goal is to regulate behaviors that maintain proximity to and contact with a discriminated protective person, referred to as *the attachment figure*. (p. 1063).

According to Bowlby, all infants will become attached to a caregiver; however, it is the *quality* of attachment that will vary according to the care-

giver's responsiveness to the infant's signals and emotional availability in activating the infant's attachment behavioral system (Bretherton, 1992; Sroufe, 1986). Through continual interactions with others, the quality of the child's attachment is established and he or she constructs an increasingly complex 'internal working model' of others and self in relationships. Such an internal working model functions as a guide in appraising situations and directing behavior for future relationship interactions. For example, if a child has had experiences that has led him or her to construct a model of the attachment figure as very responsive, close monitoring of the attachment figure's whereabouts may be less necessary than for someone for whom such attentiveness has not been experienced (Bretherton, 1985).

Based on assessments of behavior in the so-called Strange Situation, children between 12 and 24 months can be reliably classified as securely or insecurely attached. Ainsworth defined three attachment categories—one secure, two insecure—by examining infants' behavioral strategies coded during the reunion sequence of the Strange Situation. Those infants who responded with heightened efforts to gain and maintain proximity and contact with the caregiver upon her return and displayed little or no avoidance or ambivalent behavior (e.g., gesturing to be picked up and then arching the back away from the caregiver) were labeled "secure". By contrast, infants who actively avoided mother on her return or showed little proximity-seeking behavior were called insecure-avoidant; infants who simultaneously sought closeness while displaying angry and rejecting behavior were called insecure-resistant (Ainsworth et al., 1978; Sroufe & Waters, 1977). Security of attachment to mother has been found stable from 12 to 18 to 20 months of age so long as there are no major changes in life circumstances (Main et al., 1985).

While hypothesized to be guided by an 'internal working model of attachment'—a mental system, the Strange Situation relies on descriptions of the organization of nonverbal behavior for its classifications. In a move to the level of representation, researchers devised systems to assess the quality of attachment in older children and adults which tap the representational and language-based expression of individual's internal working models (Main et al., 1985). Defining internal working models as "a set of conscious and/or unconscious rules for the organization of information relevant to attachment and for obtaining or limiting access to that information... [about] self in relation to attachment" (Main et al., 1985) researchers have been able to study the inter-generational transmission of models of relationships and thus the effect of aspects of mother's character or personality structure on their children.

The Adult Attachment Interview (George, Kaplan, & Main, 1985) is a structured interview measuring an adult's current "state of mind with respect to attachment" (their 'internal working models' conceived of as generalized to their attachment history in its entirety). This interview asks repeatedly for memories in two forms: overall generalized evaluations and descriptions of experience ("semantic" memories) and specific biographical episodes ("episodic" memories) (Main & Goldwyn, in press). Subjects are asked to describe their relationships with each parent during childhood, choosing five adjectives that describe each relationship and then supporting these choices with specific memories. They are asked what they did when upset as children; whether parents were ever threatening with them in any way; whether they ever felt rejected in childhood; why they think their parents acted as they did; and how they think their early experiences with parents have affected their adult personalities. Parents are also asked about persons other than parents

who acted as parent figures; experiences of separation; and loss of parents or parental figures.

After rating subjects' responses on how loving the parent "probably" was toward the subject in childhood, the verbatim transcripts from the AAI are coded according to four scales: Coherency versus incoherency; idealization; lack of memory; and expressed anger. Importantly, scoring depends less on reported events and more on the degree to which the adult has integrated his or her experiences and the feelings they engendered (Benoit et al., 1989).

Transcripts are rated high on coherency when the presentations offered at the semantic level are supported by episodic ones of actual experience, when speech throughout flows easily and queries are directly addressed. Transcripts rated relatively incoherent are ones in which there are logical or factual contradictions, when generalized descriptions of parents are contradicted by specific memories, when there are significant slips of the tongue ("I died when my mother was 14"), when there are pauses or omissions of information, and when the speaker seems unwilling or unable to stay involved in the interview. Idealization is understood as a kind of incoherency in which favorable statements about parents are contradicted by autobiographical information or the subject is unable to back up such descriptions with specific examples. Lack of memory is scored high when a subject insists on an inability to recall autobiographical memories—even when such memories are offered. Finally, transcripts are rated according to the degree to which the subject expresses anger towards a parent during the interview. High expressed anger scores are giving when the theme of anger towards a parent dominates the interview and the subject seems to actively want the interviewer to confirm their experience of the parent. (Main & Goldwyn, in press; Benoit et al., 1989). According to these four scales, subjects are classified as secure/autonomous or

insecure/dismissive or insecure/preoccupied; a fourth classification, insecure/unresolved, was later added (Main & Goldwyn, 1991).

Secure/autonomous adults value attachment relationships and see them as influential but also show independence and objectivity in evaluating these relationships. They either present a believable picture of one or both parents as being emotionally responsive to them or refrain from idealizing an un-supportive parent or denigrating one; they are reflective and thoughtful. They are tolerant of imperfection in themselves and others. The characteristic most important for giving the rating of "secure" is coherency. The secure subject is at ease with and shows fluidity around discussions of his or her past and its influences (Main & Goldwyn, in press; Benoit et al., 1989). Furthermore, with this emphasis on the way someone constructs their story rather than on the events per se that happened, someone whose childhood was painful still can be seen as securely attached based on his or her ability to describe what they endured in an integrated way. For example, when one mother who had been strongly rejected by her family was asked the initial AAI question to "describe the nature of her early relationships," she "laughed and asked 'How many hours do you have? Okay, well, to start with, my mother was not cheerful, and I can tell you right now, the reason was that she was over-worked'" (Main et al., 1985, p. 96). In this woman, as in other securely attached subjects, the unfavorable attachment experiences and the accompanying emotions are considered and integrated into her life narrative and sense of self and others.

The dismissive adult devalues relationships, attachment experiences, and their influences. In addition, this subject may state that she has no memory for childhood. These adults are likely to score high on idealization as they

give highly favorable semantic descriptions of their parents which they are unable to support with specific memories.

The preoccupied adult seems immersed in the relationships with her parents and lacks objectivity about them. They can still seem dependent on their parents and as if they are actively trying to please them. Often these interviews are marked by intense anger towards the parents or a striking passivity regarding what happened in childhood. While these subjects may have access to early memories, they seem poorly integrated so that a subject may oscillate between good and bad evaluations of the parent. Finally, unresolved adults exhibit a lack of resolution of mourning for a significant loss through death (Main & Goldwyn, in press; Benoit et al., 1989).

Numerous investigations have demonstrated an impressive correspondence between parent attachment organization as assessed by the AAI and infant attachment organization as assessed in the Strange Situation (Eichberg, 1987; Main & Goldwyn, in press; Main et al., 1985). In these studies, secure/autonomous, dismissive, and preoccupied adult attachment classifications correspond to secure, insecure/avoidant, and insecure/resistant respectively. Initially, a possible interpretation of this generational correspondence of attachment was that the adult attachment organization is being shaped by experiences with a particular infant (secure, insecure) who is unconsciously the focus of the interview when attachment history is being discussed with the adult. However, as several investigators have shown that pre-natal AAI interviews can predict infant-mother attachment at one-year, (Benoit & Parker, 1994; Ward & Carlson, 1995; Fonagy, Steele, & Steele, 1991; Slade & Cohen, 1993) there is clear evidence that—even with giving the infant its due in contributing to the dyadic interaction—the mother's organization of attachment, an aspect of her personality make-up, influences her child's expe-

rience of and ensuing organization of relationships. Directed by the mother's internal working model of attachment, the child is responded to in certain ways and out of such interpersonal experiences constructs his or her own internal working model of attachment that, more often than not, closely resembles the mother's.

Most researchers have hypothesized that a secure mother transmits security to her infant through sensitive, attuned caretaking and emotional availability and that insecurity is transmitted through misreadings and distortions of emotional communication (van IJzendoorn, 1995; van den Boom, 1994; Frank, Tuber, Slade, & Garrod, 1994). While some refute the link between maternal sensitivity and child attachment status—reinterpreting the data as a result of child temperament (simply put, easy to soothe child is easy to care for and becomes securely attached) (Fox, 1995), numerous other studies have provided empirical support for this hypothesis by showing that 1-year-old infants of mothers rated as highly sensitive are significantly more likely to be securely attached than those of mothers rated less sensitive: (Isabella, 1993; Pederson et al., 1990). In particular, one prospective study experimentally manipulated sensitive caregiving and related it to a later test of attachment status (van den Boom, 1994). In this study, irritable infants were randomly assigned with their mothers to either an experimental group or a control group. In the experimental group, mothers were given three months of skills training designed to enhance maternal sensitivity. van den Boom found that intervention group mothers were significantly more sensitive after their training and that by twelve months of age significantly more intervention group dyads were securely attached than control group dyads (van den Boom, 1994). Other research has shown that mothers classified as securely attached on the AAI are able to respond to a wide range of their infants' affects whereas insecure

mothers either show a tendency to either minimize or maximize negative affect (Haft & Slade, 1989). According to Main and colleagues (Main et al., 1985),

Parental 'insensitivity' to infant signals, then, may originate in the parent's need to preserve a particular organization of information or state of mind. Attachment relevant signals originating externally from the infant and internally from memory may be similar in the 'rules' they evoke for parents who are insecure in terms of their own internal working models of attachment. The need to restrict or reorganize attachment-relevant information, whether it originates internally or externally, may result in an inability to perceive and interpret the attachment signals of the infant accurately and, in some cases, in an active need to alter infant signals or to inhibit them. To summarize, where the parent's own experiences and feelings are not integrated, restrictions of varying types are placed on attention and the flow of information with respect to attachment. These restrictions appear in speech in the form of incoherencies [on the AAI] and in behavior as insensitivities [during interactions with their children].

In FTT children, studies have found high rates of insecure attachment (Ward, Kessler, & Altman, 1993; Crittenden, 1987; Gordon & Jameson, 1979) as well as less maternal sensitivity compared to controls (Ward et al, 1993). Specifically, Ward and her colleagues found that controls were almost twice as likely to be securely attached as FTTs (64% versus 35%) (Ward et al., 1993). In finding that mothers of FTT children more often had insecurely attached children and received lower sensitivity scores than mothers of control children, Ward, similar to Fonagy's search for explanatory models (Fonagy et al., 1993) questions "the reasons for high rates of maladaptive mother-child attachment in FTT" (Ward et al., 1993, p. 219). Citing Polan (Polan, Leon, et al., 1991), she and her colleagues hypothesize that potentially high rates of psychopathology in mothers may play a role. These researchers assert that "the mother[s'] affective disorders may interfere with [their] ability to provide the

consistently responsive [sensitive] care that leads to secure attachment" (Ward et al., 1993, p. 219).

Other studies have shown that mothers of FTT infants are significantly less likely to be classified autonomous than are mothers of hospitalized children with normal growth patterns (Benoit et al., 1989). The authors see these insecurely attached mothers of FTT children as having relationships with their infants organized by themes of rejection, role reversal, and fear. Furthermore, according to the authors, their attachment status suggests a tendency for having disordered caregiving relationships which include not only "interactional difficulties but aberrant interpretations and subjective experiences of their infants" (Benoit et al., 1989, p. 196). Benoit and her colleagues hypothesize that, along with specific characteristics the infant brings to the dyad, the mother's insecure attachment may produce a disordered relationship, which, in turn contributes to a serious feeding problem. In this one study of adult attachment (Benoit et al., 1989) there was a preponderance of "preoccupied" attachment classification in the mothers of FTT children (61% compared to 20% in the control group). Specifically, they understood this finding as suggesting that mothers of FTT children are not only insecure, but "passive, confused, enmeshed, or intensely angry with respect to past attachment relationships" (p. 196). Benoit and colleagues note that further research could clarify the nature of the disturbances in the mother-infant relationship in cases of FTT. These authors suggest that their results should be "extended" to "identify dyadic interactions that may accompany various internal representational inadequacies and incoherencies." (p. 199).

These attachment studies on FTT serve as models of explanatory research and as points of departure for this study. Specifically, Ward's (Ward et al., 1993) investigation answers and raises several questions: Can her finding of

less sensitivity in mothers of FTT children be replicated? Even if sensitive caregiving is a major conduit for facilitating a child's secure attachment, how exactly does less sensitive caregiving contribute to FTT? And, finally, in attempting to answer why some mothers are insensitive with their children, can more be learned about the nature of mothers' emotional functioning and how it contributes to their interactions with their child and their child's feeding problem? The Benoit study confirms other attachment researchers' findings: insecurely attached mothers tend to have insecurely attached children (Eichberg, 1987; Main & Goldwyn, in press; Main et al., 1985); however, not all insecurely attached adults and children make-up dyads in which the child is failing to thrive. Could qualities of internal representations in mothers whose children are failing to thrive be further delineated and related to their behavior with their child and their child's FTT status? Taken together, the Ward and Benoit research projects offer an interesting scaffolding for this study. Following Benoit, this study is designed to further delineate the nature of mothers' "inadequate" and "incoherent" internal representations as they relate to the mother-child interaction and potentially contribute to the child's failing to thrive. Following Ward, these investigations of maternal representations will be used to focus on why some mothers are less sensitive with their children (and have less mutual and productive feeding experiences with them) (Chatoor, Egan, et al., 1988; Lobo, Barnard, & Coombs, 1992) and how these findings potentially relate to FTT.

A psychoanalytic approach to object representations:

In order to broaden the exploration of internal representations, this study will use a psychoanalytical orientation and tool to systematically examine

mothers' internal object representations. A psychoanalytic theory of object relations will be used because it can potentially expand the understanding of mothers' internal object representations based on four specific factors. The four factors are: (1) psychoanalytic theory can further illuminate internal representations by its emphasis on the self–other representational matrix (Klein 1958; Fairbairn, 1946; Ogden, 1993), its idea of multiple internalized self–other representations, and its conceptualizations of projection and transference; (2) psychoanalytic theory's inclusion of endogenous stimulation (drive) and phantasy in the construction of representations leads to an assumption of non–veridical representations (Silverman, 1995; Slade & Aber, 1992) which, in turn, suggests alternative ways to interpret the significance of representations; (3) psychoanalytic theory can provide a tool that operationalizes object representations which, unlike the AAI, does not have a conscious link to parenting issues (Ricks, 1985; Frank et al., 1994), thus allowing for independent confirmation of the AAI data on mothers of FTT children as well as providing additional information on how these mothers represent relationships (Levine, Tuber, Slade, & Ward, 1991); and finally, (4), psychoanalytic theory can broaden the assessment of representational "inadequacies and inconsistencies" by including mothers' overall representational capacities, such as the quality of symbolization as it is an outgrowth and reflection of experiences of self and other (Drucker, 1979; Slade, 1986; Ogden, 1993). These four aspects of a psychoanalytic theory of object representation will be discussed next.

The self–other representational matrices:

A psychoanalytic model of object representations can add to the attachment perspective through its emphasis on multiple internalized relationships. The attachment paradigm is primarily concerned with "the differences

in the mental representation of the self in relation to attachment" as it is organized by an internal working model of relationships which "*directs* not only feelings and behavior, but also attention, memory, and cognition, insofar as these relate directly or indirectly to attachment" (Main et al., 1985, p. 67). In contrast, the psychoanalytic model of object representations emphasizes the self–other matrix of object representations. Specifically, the psychoanalytic model sees what is internalized as an object relationship centered on a specific affective experience—so that both self and object components are internally represented (Klein 1958; Fairbairn, 1946; Ogden, 1993). Although the most recent research in attachment theory has begun to consider the representation of "self," "other," and "relationship," (George & Solomon, 1996) its focus remains on an internalized schema which directs one's behavior and feelings involving attachment. Furthermore, whereas the attachment paradigm assumes that through development one stable internal working model of attachment will prevail (Bretherton, 1985; Main et al., 1985; Fonagy, 1996) psychoanalytic theory sees different representations of the self and other (generated from the differently-colored drive and phantasy experiences) being housed in the self (Ogden, 1993, Klein, 1946). Through transference (Freud, 1912), externalization (Novick & Novick, 1987), projection (Freud, 1911), projective identification (Klein, 1946, 1955), and actualization (Ogden, 1993) people recreate their internalized object relations with contemporary others (Greenberg & Mitchell, 1983). Two clinical examples will illustrate these points.

Casement (1985) describes an adult patient noting that his bookshelf is messy, with many books and journals open on shelves as if they were in use. This patient berated Casement for this untidiness. After the session, Casement wanted to clean up his book shelves because he, as well, likes

things clean, but felt in a bind: If he did clean up, it would appear as if he were bending to the patient's criticism; but, if he didn't, he was still under the patient's sway because he wasn't doing what he truly wanted. He compromised by putting away what was no longer in use. At the next session, the patient ridiculed him for his "pathetic compromise," of trying to be independent while still pleasing the patient. Upon reflection, Casement realized that he was truly in a double-bind; there was no way he could respond to the patient while remaining, in a sense, true to himself. Casement understood that the patient had facilitated Casement having the kind of experience the patient had had as a child; often the patient was put in such a double-bind by his mother. Now, Casement was induced into this childhood role, while the patient embodied the role of his mother. A self-object relation from the patient's internal world was enacted in treatment and a part of the patient's experience communicated in action to the analyst.

In another clinical example, Altman (1992) describes play that is centered on the therapist taking the role of a customer who is asked to leave a restaurant for unruly behavior or a baseball umpire who ejects a player (the child Tom) from the game as connected to Tom's divorced father's decision not to invite him to stay over any more. Altman (1992) writes

... On the level of symbolic play, the therapist is put in the position of the rejected customer, or the rejecting umpire. In symbolic fashion, the therapist is given the opportunity to experience and contain a bit of Tom's feelings of rejection, as well as the retaliatory anger that Tom presumably feels toward his father (1992, p. 192).

Altman, like Casement, uses the assigned roles, evidenced either in an enactment or symbolic play, to understand the patient's inner world, and, especially, in what ways self and other are represented and expected to interact.

These two clinicians are using ideas of internalized object relationships and processes of externalization to describe the same kind of dynamics Fraiberg, Rank, and the Novicks observed in failing-to-thrive children and their mothers. As in these clinical vignettes, unconscious aspects of the mothers' internal representations of self and other (perhaps affected by elements of drive and phantasy-based distortion) were often "externalized" (Novick & Novick, 1987) or enacted with their children, which, in turn, colored the mother's experience of the child (not to mention the child's experience of self (Fonagy, 1996: Loewald, 1960)) and contributed to the child's failing to thrive. For example, in the case of Betty described above (Rank et al., 1948) Betty's mother can be understood as recreating with her child struggles similar to those which she experienced with her mother. Betty's mother *revisited* this painful childhood experience, at times playing the other who relieves Betty of her deprivation (an acting out of her own childhood self wish for rescue?), at times inflicting on Betty the wretchedness she felt and becoming the denying other.

More than the attachment paradigm, the psychoanalytic one re-focuses the lens to the representation of a relationship and how a child can come to be seen as a part of the mother and the two of them re-create an externalized version of an internalized self-other relationship of the mother's.

Non-veridical representations:

To consider the second way in which a psychoanalytic perspective adds to an understanding of object representations it is necessary to consider the ori-

gins of such representations. Although attachment theory is an outgrowth of psychoanalytic thinking (Bowlby, 1982; Bretherton, 1985) there are important differences between the two in the way they construe the development of internal representations. The attachment perspective holds that working models of attachment result from the child's *actual* experience with others. In this model, internal representations are an accurate, veridical reflection of the self with others (Main et al., 1985; Slade & Aber, 1992). For example, an insecurely attached child alters his or her normal attachment behaviors in order to feel safe; "representational models are thus not distortions of reality, they are accommodations to reality" (Slade & Aber, 1992, p. 177). The psychoanalytic perspective, on the other hand, sees drive and unconscious phantasy experiences as coloring and even distorting the perceptions and interactions of self with other so that the internalized representations are not based solely on so-called reality. The psychoanalytic model can account for representational distortions and expects them.

The different views on distortion in object representation center, in part, on the debate between attachment and psychoanalytic thinkers on the conceptualization of the primary drives and their relation to objects (Bowlby, 1958; Freud, A. 1960; Jacobson, 1964; Slade & Aber, 1992).

Freud, in his original "libido theory" (1914), postulated for infancy a separation between sexual and ego- or, self-preservative instincts. In this hypothesis, the first auto-erotic sexual satisfactions are initially distinct from but "attached" to the satisfactions of the ego-instincts, which strive for satisfaction of vital needs (getting nourishment, for example). Through this "anaclitic" or "leaning-on" arrangement, in which the sexual instincts lean on the primary self-preservative instincts, Freud discovered that nature ensured species self preservation by associating it with erotogenetic satisfaction.

Children become attached to and take as their first objects those who feed, care, and protect them (e.g. , those who make them feel good by providing for their self-preservative needs) (Freud, 1914; Jacobson, 1964).

In contrast to Freud and other psychoanalysts, Bowlby (as described above) claimed that the attachment system is a distinct motivational system that rivals mating (sexual instincts) and feeding (ego preservative instincts) in biological importance (Bowlby, 1958; Bretherton, 1985). While attachment theorists depict Freud as ignoring the significance of the object and having the "infant becom[ing] related to his or her parents as a by-product of the quest for drive satisfaction" they assert the inverse, that the baby is primed from birth to establish social relations which guarantee his or her survival (Slade & Aber, 1992, P. 175). Bowlby believed other psychoanalysts weren't seeing the importance of the caregiver, the object, to the outcome of early development and psychoanalysts felt Bowlby and his followers missed how impulses (and wishes) can lead to distorted internalized object representations. What Bowlby didn't see, however, was that for Freud, the object was always as an integral part of any drive process (Pine, 1985)—Freud just chose most often to emphasize the internal, subjective experience of the other over an objective, outsider's view of the mother and child interacting (Ellman, 1995; Jacobson, 1964).²

² Another reason Freud's (and other psychoanalytic theorists') drive theory is rejected is because it is viewed as underestimating the importance of attachment or object relations due to the conceptualization and description of developmental stages from the infant's perspective (Ellman & Monk, in press). Freud's delineation of autoerotic and narcissistic stages, like Mahler's (Mahler, Pine, & Bergman, 1975) use of the terms "autistic" and "symbiotic," causes people to mistakenly view these psychoanalytic theories as missing the importance of the other to the developing baby (Slade & Aber, 1992). However, what these theories, as well as Winnicott's (1956) and Loewald's (1971) emphasize is that the caregiver's role in the infant's first months is one of intense attunement and management of his or her physiological experiences. While the child can use smell and vision to recognize his or her primary caregiver within the first weeks of life (MacFarlane, 1975; Brazelton & Cramer, 1990) and has "moments" of being related (Pine 1985), these cognitive capacities do not negate the

Freud viewed the object as “what is most variable about (an) instinct” (Freud, 1915, p. 65), but he realized the interconnection of objects and drives. For example, early on when Freud delineated the various causes of anxiety neuroses, he hypothesized that excessive masturbation causes neurasthenia. If Freud were a pure drive theorist who saw drive experiences only as discharge processes (as he sometimes seemed to with his analogies relating sexual satisfaction to hydraulic pumps) discharge through onanism would not lead to neuroses, discharging one way would be as good as discharging any other way.³ It is precisely because Freud saw the object and drive as interconnected that he could understand how drive can affect the internalization of the object representation.

To contemporary psychoanalytic theorists “drive satisfaction and object rapidly become interwoven and as circular as chicken and egg” (Pine, 1985, p. 61). Because a psychoanalytic perspective includes objects in its conceptualization of drives, the subjective experience of drive is understood to influence the interactions, processing, and internal representations of self with other (Klein, 1940, Jacobson, 1964; Kernberg, 1975). Even innate aggression—following from Freud's second libido theory which included a death instinct—is believed to color interactions with and representations of the self with other (Freud, 1920; Klein, 1937).

psychoanalytic hypothesis that infants' subjective experience is one of non-separateness from the caregiver. Furthermore, a description of subjectively-experienced interconnectedness is not a denial of the importance of the other, quite the contrary. Drive theorists like Winnicott and Loewald see the caregiver's handling of the infant's experience (and the infant's experience of that handling) as impacting greatly on that child's development.

³ While any inaccuracies are mine, these ideas are Dr. Steven Ellman's. In a recent interview with Mitchell (1994), Ogden contradicts his interviewer's popular characterization of Freud, describing Freud's view on the relation between drive and object relations as follows: “Freud's view of the relationship between object relations and sexuality is, in fact, much more complex than that of the simple drive discharge model ... often attributed to Freud (in which) the object is merely the avenue through which drive tension is discharged.”

Thus, a psychoanalytic theory of object relations and representations sees the pursuit of pleasure, along with the push to express intrinsic aggression, as interwoven with experiences of self and other in relationships. These internal drives operate so as to "distort reality, compromise perception, and complicate both the formation of object relations and the development of internalized representations" (Slade & Aber, 1992 p. 176). Experiences of drives and their derivatives, for example, of need tension around hunger, bowel pressure, release, and the bodily stimulation of being cleaned (Pine, 1985) will contribute to the internal representation of self with other just as the other's handling of the self will. The caregiver is internalized along with "the complex mesh of drive and affect that constitute the infant's interactive history with her" (Slade & Aber, 1992, p. 176). Drives, intimately connected to object relationships, will contribute to a highly subjective—even distorted—perception and internal representation of these self–other experiences.

In a psychoanalytic model of object relations and representations a second factor that accounts for representational distortion is phantasy. In this model, preconscious and unconscious phantasy "underlies and colors all our activity however realistic ... [phantasies] underlie dreams, symptoms, perception, thought, and creativity" (Segal, 1991, p. 101, p. 30). Phantasy is seen as originating in internal instinctual impulse and as being, at its base, the mental corollary, the psychic representative of instinct (Isaacs, 1952, p. 83). "Phantasies are active along with the impulses from which they arise" (Isaacs, 1952, p. 75); They are "the language of primary instinctual impulse" (Isaacs, 1952, p. 107) and the constant companion of bodily experiences—whether endogenous or exogenous in origin. Physical experiences are "interpreted as phantasy object relationships, giving them emotional meaning" (Segal, 1991, p. 20). A moment of common displeasure, such as waiting to be fed, could contribute to

the creation of an internalized hating other and a hurt self based on the rageful phantasy evoked during the frustration of feeling overwhelming tension and discomfort. While the existence in children of erotic and aggressive impulses and their accompanying phantasies is often doubted, Slade and Aber (1992) point out that attachment theory has a difficult time accounting for this kind of phantasy routinely seen in secure two- or three-year-old children (e.g., a secure girl with a new baby brother playing with a miniature baby saying "Baby fall on the floor, smash its head open!"). This child's statement clearly reflects a distortion of reality that must be related to her phantasies and wishes.

The psychoanalytic view of object relations and internal representation considers, along with real interactions, the wishes, needs, and phantasies shaping perceptions and experiences with others (Silverman, 1995). While the attachment perspective emphasizes the ways in which internal representations (an Internal Working Model of attachment) are based on reactions to what actually happened, a psychoanalytic model adds to this 'reaction to reality' the subjective experience influenced by drives and phantasies. In this model, the child is an active processor of his or her experience and internalized representations of self and other are based on interactions with others as well as on *the manner in which these experiences get organized under the influence of drives and phantasies*. Thus, in this model—the antithesis of a learning model—representations can be distortions of what 'in reality' happened. Furthermore, not only can the representation of an aggressive interaction from a secure child (the child described above) be accounted for but one would expect representations of aggressive, imbalanced, and sexual object representations even in a secure child or adult.

This perspective on object representations has received some support in a study by Frank and colleagues (Frank et al., 1994) showing that mothers who went on to raise securely attached infants "were consistently more able to give voice to frank and uninhibited expressions of sexual, aggressive ... material and integrate such affectively laden content into a perceptually convincing gestalt" (p. 484) on a Rorschach test administered when the women were pregnant. As a psychoanalytic model would predict, it is not primarily the content of the varied self–other representations themselves (as they are not mere reflections of reality) that signify psychological health, but what one does with them, e.g., how they are managed intrapsychically and interpersonally, that offers insight into emotional well being.⁴

Fraiberg's case studies of FTT children and their mothers suggests that many of these women do not have access to their emotional experiences. Rather than assess as healthy a person whose representations of others omit any reference to imbalanced or aggressive interactions, a psychoanalytic model would illuminate the potential problem, seeing this as indicative of internal processes blocking access to the representation and/or expression of such experiences.

The interface of attachment and psychoanalytic theories:

A third reason to add a psychoanalytic perspective to the understanding of object representations centers on validating and expanding the AAI data of

⁴ This emphasis on 'what one does with' internal representations over their content is somewhat similar to the attention given on the AAI to the quality of the narrative rather than the events per se of someone's life. However, in the attachment paradigm, that allowance is given to someone who in reality had 'bad experiences' and worked them through whereas in the psychoanalytic perspective 'bad'—aggressive, hurtful—representations are assumed to be more universal; the effect of hypothesizing innate drives and phantasy is in evidence.

mothers of FTT children. There is a growing body of literature examining the commonalities and divergences of psychoanalytic and attachment theories (Diamond & Blatt, 1994; Frank et al., 1994; Levine et al., 1991). A psychoanalytic approach to mothers' object representations would provide the opportunity for contributing to this interface by showing convergent validation of past AAI findings with results from this study's different assessment of maternal object representations (Urist & Shill, 1982). Such research would add empirical data conceptualized from a psychoanalytic perspective to the findings that mothers' object representations impact on the mother-child interaction and the child's development (Levine et al., 1991; George & Solomon, 1996; Zeanah, Benoit, Hirschberg, Barton, & Regan, 1995) as well as offer additional detailed information about these women's internal representations.

Many recent studies have used various scales applied to the Rorschach to measure a subject's internal object representations (Blatt, Brenneis, Schimek, & Glick, 1976; Blatt & Lerner, 1983; Urist, 1977; Urist & Shill, 1982; Levine et al., 1991; Tuber, 1983; Meyer & Tuber, 1989; see Stricker & Healey, 1990 for a review of the literature). One of these object representations measures is the Mutuality of Autonomy Scale (MOAS) (Urist, 1977) which assesses subjects' interactive Rorschach percepts along a 7-point continuum ranging from mutual, reciprocal relatedness to imbalanced, toxic, and catastrophic ones (Urist, 1977, Urist & Shill, 1982; Tuber, Frank, & Santostefano, 1989). Some studies have shown that the scale may be a better indicator of levels of pathology (Blatt, Tuber, & Auerbach, 1990) but others have found it to be a sensitive instrument in the delineation of people's inner representational worlds (Tuber et al., 1989; Meyer & Tuber, 1989).

The MOAS offers a unique opportunity to corroborate and expand on the AAI results of mothers whose children are failing to thrive. As described

above, this research has shown that mothers of FTT children are most often rated as insecure on the AAI. Thus, based on the four scales used to judge adult attachment on the AAI—coherency, idealization, memory, and expressed anger—mothers of FTT children are found to show incoherent narratives with respect to attachment, heightened idealization, a lack of memory, and to become passively preoccupied with their expressions of anger. To provide concurrent validity, one could test corresponding results on the MOAS. For example, when FTT mothers produce object representations on the Rorschach, are these representations unidimensional and predominantly angry? Or, relying on idealization, predominantly benign? Do these women not represent the spectrum of interactions (positive and negative) similar to Fraiberg's clinical cases? Consistent with weak memory regarding attachment, do they produce fewer representations on the MOAS?

Furthermore, as the attachment paradigm assesses the capacity to reflect on experiences and thus considers an openness to and integration of *all* experiences, similarly (as briefly discussed above) a psychoanalytic model considers defensive processes interrupting the integration of and access to experiences as well as the inability to represent some experiences. Again, this was evidenced in Fraiberg's clinical work with FTT children and their mothers when she observed defensive processes limiting mothers' abilities to represent and access the range of emotional experiences in their inner worlds. A psychoanalytic perspective on object representations cautions that someone lacking representations of aggressive or imbalanced interactions does not necessarily suggest that there were only positive interactions in that person's emotional history but rather that the power of internal processes such as defenses are limiting that person's ability to represent and access other kinds of experiences. This is further evidence supporting the hypothesis that the

MOAS scores of FTT mothers would be uniform, a consequence of the fact that these women are most likely unable to reflect on and integrate different kinds of experiences, that they are cut-off from and defending against the full range of emotional interactions.

However, because the Rorschach, unlike the AAI, does not make a conscious link to relationship concerns (Frank et al., 1994) (and subjects are unaware of the MOAS assessment) and the two scales—AAI and MOAS—are unrelated measures, support for the AAI findings from this different paradigm would be all the more striking. The child's FTT status and mother-child behavior predications made from MOAS ratings of maternal object representation would also add to the growing body of psychoanalytically-informed, empirically-grounded research on the connection between inner experience and interactive behavior specifically as it concerns a mother and her child. Finally, comparing mothers with FTT children to mothers of controls will also provide new detailed information about their inner representational worlds.

Symbolic processes:

The fourth area into which psychoanalytic theory expands the object representation inquiry is overall representational capacity, particularly the quality of symbolization. Beginning with work investigating children's verbalization of attachment issues (Main et al., 1985) and the AAI's attention to how someone structures and integrates experiences in their narrative (Main & Goldwyn, 1991), attachment researchers have been using ratings of representational style (over the content of representations) to gauge the quality of attachment e.g., fluidity of discourse, coherency. This approach has led to recent research on metacognitive capacity (Main, 1991; Fonagy (1996). In this

work, caregivers' ability to appreciate the "merely representational nature of their own (and others') thinking (Main, 1991, p. 128)—their ability to 'realize' that their mind represents something to them in a way which may be perceived by and represented to other minds differently—is associated with their child being securely attached (Fonagy, 1996). In essence, the caregiver's ability to appreciate and tolerate the distinction between immediate experience and the mental states which process it and represent it, a distinction which allows for multiple perspectives of and reflection on the same event—a flexible mind—is seen as an indication of secure attachment as well as hypothesized to lead to secure attachment in the child. This is seen as the opposite of narcissistic, concrete, and stimulus bound thinking; here, there is differentiation or space between an event and the mental representation of the event. As Fonagy (1996) describes it

Our formulation was based on the assumption that the psychological process underpinning the view of oneself and others as motivated by mental states, what the philosopher Dennett (1978) calls an 'intentional stance,' which is variously labeled as 'metacognitive monitoring,' 'mentalization, or more narrowly as 'the child's theory of mind,' or 'reflective self function' is a developmental achievement which emerges *fully* only in the context of a secure attachment relationship. ... The child not only perceives in the caregiver's behavior her stance of reflectiveness which he infers in order to account for her behavior, but before this he also perceives in the caregiver's stance an image of himself as mentalizing, desiring, and believing. He sees that the caregiver represents him as an intentional being. It is this representation which is internalized to from the self (p. 73).

Psychoanalysts also have been interested in the quality of representation, how this capacity develops and what it reveals about a person's functioning. For their explorations they have focused on symbolic processes including the ways in which an object is substituted for another (Klein, 1930; Winnicott; 1971; Slade, 1986; Ogden, 1993) a word stands for or signifies something (Klein,

1923; Schimek, 1975), and language is more or less flexibly used to represent experience (McDougall, 1989; Ogden; 1993; Schimek, 1975, Joseph, 1988). According to Rodrique (1956) "previously analysts asked: what is the content of a given symbol? Today another question is added—in what way is the content expressed by the symbol?" (p. 153). Joseph (1988) states it as follows: "With unreachable patients focus one's attention on the patient's method of communication, the actual way he speaks ... rather than concentrate(ing) on the content of what he says (p. 49). Winnicott (1971), using his metaphor of play to stand for the capacity (which he saw on a continuum) of being able to have *something*, an object or a word, be seen for what it is as well as stand for something else, said that therapists were "too busy looking at play content to look at the playing child" and felt that "when a patient can't play, one must attend to this first" (p. 47).

Psychoanalysts see the development of symbol formation as intimately interwoven with early caregiving experiences as well as view the quality of adult's symbolic processes as bearing the stamp of these beginning object relations. As Segal (1957) put it "the way symbols are formed reflects the ego's state of development and its way of dealing with objects" (p. 183). This perspective on symbolic processes makes a link between one's object relations—the management of self–other differentiation and multiple perspectives—and the capacity to symbolize.

Theoretical formulations accounting for the development and later qualitative deficiencies of symbol use differ according to which Freudian instinct theory is followed: his first, need versus desire; or, his second, Eros versus Thanatos. Winnicott and Ogden link symbol creation with the emergence of experiencing desire while the Kleinians see it as a way to protect objects from the child's overwhelming destructive and libidinal drives. Both perspectives

see symbolic development as dependent on the working through of self–other differentiation. These two seminal theories of symbol development will be briefly discussed.

Winnicott assumed that no human being completes the requirement of what he termed “reality acceptance” and that therefore each of us struggles under the strain of relating inner (subjective, phantasy) reality with outer (objective, consensual) reality. Relief, however, is provided by an “intermediate area of experience”—transitional space—that is never challenged. In this “third area of experience” symbols are born.

According to Winnicott, infants depend on maternal care stemming from maternal empathy rather than on “an understanding of what could be verbally said” (1960, p. 40). Mothers use their narcissism and memories to enable them to know through identification what their baby needs. He thought the impetus for symbol formation was the experience of the separate existence of the object, the change from mother–child communication based on maternal empathy to mother–child communication based on the child *indicating* a wish, which is seen as part of growth. On the way to indicating needs is the development of transitional space: As the infant is weaned from the “maternally provided psychological matrix” and begins to separate out the me from the not-me (when the child is between four and twelve months old), he or she holds a “series of paradoxes: infant and mother are one; infant and mother are two ... The infant’s simultaneous maintenance of the emotional truth of oneness with the mother and separateness from her (a maintenance of more than one reality or perspective) makes it possible for the infant to play”—to know multiple meanings and “as if” experiences, and ultimately, to symbolize (Winnicott quoted in Ogden, 1993, p. 187). Transitional space is thus a developmental milestone ushering in the capacity to maintain a psy-

chological dialectical process of multiple perspectives including inner and external realities, subjective, phantasy and objective realities, and distinct self and other viewpoints. Symbol use necessitates this capacity to maintain a psychological dialectical process as symbol use depends on the multiple views of having something stand for something and also be seen as itself. When developmental experiences limit the opportunities to move between multiple perspectives—either through a caregiver's narcissistic need to be mirrored or their overly "good enough" matching of their child's subjectivity so that, either way, only one view exists, there will be qualitative deficiencies in symbol use given that a psychological dialectical process will not have been adequately developed and maintained.

For Kleinians, anxiety stimulates symbol formation. Similar to Winnicott and his followers, the Kleinians describe a dramatic qualitative shift in symbol formation concurrent with children's emerging sense of separateness from mother. For the Kleinians this stage, occurring in the second half of the first year, is called the depressive position. Infants are thought to experience a sense of concern for objects based on their dawning awareness of separateness from them, of needing them, and of what their aggressive and possessive urges might do to them. Symbols are needed to displace aggression from the original object in order to protect the object from the child's violent wishes (Segal, 1957, p. 167). In this way, symbol formation primarily functions to deal with anxiety and guilt generated by the phantasied attacks on the maternal object. "The anxiety gets worked over in a better way by distribution amongst new things and interests" (Klein, 1930, p. 229). Additionally, symbols are used to overcome the loss of omnipotent control over the object (as compensatory replacement) and as alternatives for prohibited instinctual desires: "When a desire has to be given up because of conflict ... it may express itself in a sym-

bolic way; an object of the desire, which had to be given up can be replaced by a symbol" (Segal, 1991, p. 32). While moderate anxiety resulting from aggressive and libidinal drives (before Klein's theoretical changes postulated after 1932) spurs symbolic development, too great "has a freezing effect on mental growth" (Rodrique, 1956, p. 152). Deficits in the quality of symbolization result, in part, from an overwhelming level of anxiety so that links to symbolization are not made and some drive-based experiences are cut-off from intrapsychic processing rather than set into the chain of symbol development. As failure to move into the depressive position from what Klein called the paranoid-schizoid one results from overwhelming, uncontained anxiety and means that the child functions in a split, me, not-me world (a world to which we all return at various times) Klein's theory of symbol development is also, implicitly, rooted in object relations (Ogden, 1993). For true symbolization to develop and be used there must be a sense of separateness of self from other which includes the capacity to feel from the other's point of view, thus an implicit awareness of one's own subjectivity and the other's. Like Winnicott's theory of symbol development, Klein's requires self-other differentiation. As Segal describes it:

Symbolism is a tripartite relationship: the symbol, the object it symbolizes, and the person for whom the symbol is the symbol of the object. In the absence of a person there can be no symbol. That tripartite relationship does not hold [when] ... [t]he relevant part of the ego is identified with the object: there is not sufficient differentiation between the ego and the object itself, boundaries are lost, part of the ego is confused with the object, and the symbol which is a creation of the ego is confused with what is symbolized. It is only with the advent of the depressive position, the experience of separateness, separation and loss, that symbolic representation comes into play (1991, p. 38).

In one of the few studies to examine the link between early object relation experiences and symbol development, Slade (1986), using Mahler's theory of

the separation–individuation process (Mahler et al., 1975), found powerful support for this general hypothesis. In her naturalistic study of 2–year–old boys, she observed that the quality of the children's symbolic play was related to their progress in negotiating the emotional acceptance of separateness from the mother and internalizing a representation of her. In particular, Slade found that transformational play (having something represent something else, such as a block for a boat) and role play were especially sensitive to the vicissitudes in self–other differentiation: when a child showed weakness around self–other differentiation and boundaries, he seemed to lack the flexibility to "play" with identities and allow something to stand for something else as well as still be acknowledged as 'itself'. Instead, he needed to use concrete props to support his sense of himself and reality (Slade, 1986). Slade (1986) states

The greater the degree of inner stability and integration, the greater the availability of flexible and complex modes of symbolic expression. And the more diverse the capacity for symbolic expression and transformation, the greater the opportunity to further practice, enhance, and delineate self and object representations through play (p. 560).

From a psychoanalytic perspective, symbolism, as a mode of representational capacities, reflects the quality of object relations. Symbolic processes depend on the sufficient differentiation of self and other and the related capacity to contain a psychological dialectical process, including 'seeing' from different perspectives. In order for *something* to stand for *something* else without becoming that *something* else, there must be a security in identity (in order to play with identities) as well as the mental flexibility to allow for one's subjective perspective (the block is a boat) while also accepting the objective view (it's a block).

In assessing the quality of adult symbolization, three groupings of weaknesses will be described (Ogden, 1993). (1) A word or thing does not stand for something but is seen as it. Equivalency reigns between the symbol and symbolized, manifested in concrete thought. For example, when a patient who needs something of the analyst's to hold onto during vacations and is given one of his books, she views it not as standing for or holding the analyst's place, but as a piece of him to have in his absence (McDevitt, 1993). This patient's private, subjective meaning takes over; it cannot be maintained in the context of also "seeing" reality.

Use of this kind of symbolic equation most likely occurs in different levels of functioning: psychotic and borderline disturbances in people who try to change reality to conform with their inner life; people with narcissistic disorders who "have made peace with reality on the condition that they don't always have to live in it" (Bach, 1980, p. 173). The latter also could include those immersed in fantasizing and a schizoid withdrawal as well as the narcissist, struggling with problems of self and object constancy, having others in the external world as extensions of him or herself and his or her inner, subjective life.

The second (2) kind of qualitative deficit in symbolization occurs when there is little play with symbolic meanings, when 'a cigar is just a cigar.' Here, "the fixity of the person's focus on reality is in fact designed to drain the blood out of phantasy. The person is left without imagination" (Ogden, 1993, p. 219); No multiple meanings, no ambiguities, no containment of multiple perspectives. In the context of describing how such people transform instinctual energy (drive) into more personalized, higher psychic structures, Loewald notes their proclivity for "mere superimposition." Rather than restructure what is less organized and more subjective, they keep it out of their overall organiza-

tion; they defend against reorganization by superimposing forces (using repression) against it. He identifies such people as obsessionals or "normal characters." Superimposition causes them to have "a lack of attachment of words to objects, (a) lack of (a) link between the unconscious and conscious..." (Loewald, 1971, p. 103). Hence, words and other symbols are one dimensional entities, flattened to a singular existence. People like this are internally swayed to the reality pole (versus the subjective, phantasy pole) and thus overly defended and constricted. They have dull personalities and are emptied of daydreams (Loewald, 1971).

The third (3) variation of symbolization disturbance is seen as somatization. This process occurs when "[t]here is a cessation of attribution of meaning to perception" (Ogden, 1993, p. 215). Potential thoughts and feelings are "neither attributed symbolic meaning nor given existence. There is a psychosomatic foreclosure on meaning" (Ogden, 1993, p. 102). For example, a patient anticipating an analyst's holiday left a session to vomit. The analyst's departure was extremely painful to the patient, but instead of this message being sent by the psyche and transmitted through the symbolic chain of verbal thought and word presentations (internal affective communication conveyed through symbols), there was a short-circuit in the links of language. The psyche's message was registered as a thing presentation. Thing presentations are "dynamically powerful, unconscious elements expressed in the form of perceptual or somatic registration of emotional arousal, which must then be decoded by the psyche and subsequently carried into action" (McDougall, 1989, p. 53) These thing presentations provoke a direct, somatic response, such as an infant might have. Rather than symbolizing the feelings surrounding the analyst's departure (in words, or a dream, or a symptom such as "losing" car keys), the body, like a trap door, is the direct embodiment of unconscious, af-

fective experience. Meaning is foreclosed as the direct expression excludes an "I" or subjective self that can partake in a meaning-creating process and interpreting mode around a relation between a symbol and something symbolized.

Unlike the attachment paradigm's method of assessing representational quality, using a psychoanalytic model to judge symbolic processes could be based on symbolization in general. For example, how flexibly mothers are able to let the Rorschach ink blots represent something would be a possible method to examine the quality of their symbolic processes. The Transitional Object Scale (Greenberg, Craig, Seidman, Cooper, & Teele, 1985; Cooper, Perry, Hoke, & Richman, 1985) is a coding system designed for use with the Rorschach; it is based on an operationalization of Winnicott's ideas of transitional space and rates the quality of symbolization on the Rorschach. For this study, the TOS could broaden the assessment of mother's representational capacities to include overall symbolic functioning. In that symbolization is the result of successful differentiation and integration of self and other as well as of internal subjective experience with an objective perspective, it is also a barometer to this kind of functioning. An examination of symbolic processes could illuminate mothers' unconscious functioning regarding the ways she negotiates between self and other and integrates inner subjective experiences with outer, objective ones. Similar to Slade's (1986) work, use of the TOS could suggest parallels between mothers' capacity to hold multiple perspectives (seen in their ability to symbolize on the Rorschach) and their sense of and relating between self experiences and their child and how these dynamics may relate to the child's failing to thrive. Rorschach researchers have observed that people with borderline personality disorders often produce constricted Rorschach protocols or ones with an inordinate number of responses, flooding the testers with percepts and their associations to them (Sugarman,

1980). The way of making representation on the Rorschach suggest valuable information about the capacity to symbolize and navigate between internal and external experiences that warrants further study.

The psychoanalytic perspective on internal representations can add to the attachment paradigm increased possibilities for understanding internalized representations. With its emphasis on self-object matrices, non-veridical representation, projection, phantasy, drive, and overall quality of representation (including symbolization), it can significantly contribute to this study's exploration of mothers' inner representations as they relate to their behavior with their child and the child's FTT status.

Summary and Statement of the Problem

Failure to thrive accounts for 5 to 30 percent of all pediatric hospital admissions (Breunlin et al., 1983; Frank & Zeisel, 1988) and is found across racial and socio-economic groups (Ward et al., 1991). Children who suffer from it experience long-term cognitive, emotional, and physical problems (Drotar & Lynne, 1988). Known previously by different terms, its current name reflects the history of the tug-of-war over which orientation best explains its etiology: medical doctors primarily using a biological-behavioral approach and eschewing psychological factors or psychologists and psychoanalysts considering emotional factors in conjunction with physical vulnerabilities.

Of those considering psychological factors, clinical case reports (Elmer, 1960; Fraiberg 1995; Novick & Novick, 1987; Rank et al. 1948) offer the intriguing hypothesis that mothers of FTT children have difficulties assessing and representing internal emotional experience and that these qualities play a role in their children's development of FTT. These clinical studies suggest that a

mother who is cut-off to her own internalized representations of self and other has a tendency to re-create with her child an externalized version of this internal self-other relationship.

The large-scale research projects exploring psychological factors of FTT have produced invaluable information about the characteristics of the mother, the family, the child, the interaction of the mother-child dyad etc., building up significant evidence for the importance of considering psychological issues when understanding and treating FTT. However, while this work has established the common predisposing factors to and associated features of FTT, it generally has been less concerned with and successful at providing explanatory models of this disorder. On the other hand, research done within the attachment paradigm is a significant exception. Studies by Benoit and Ward have produced findings that are consistent with the clinical data (although this was not their mission), robust, and offer key building blocks for their explanation of the etiology of FTT. Mothers of children who are failing to thrive most often have insecure representations of attachment and are less sensitive when interacting with their children. As discussed in the clinical literature, these mothers cannot effectively access and coherently represent their inner experiences of self and other. Benoit and her colleagues hypothesize that, along with the specific characteristics which the infant brings to the dyad, the mother's insecure attachment may produce a disordered relationship, which, in turn contributes to a serious feeding problem. Benoit notes that further research could clarify the nature of the disturbances in the mother-infant relationship in cases of FTT through an examination of mothers' internal representational inadequacies and incoherencies and their relation to the mother-child interactions and the child's failing to thrive.

Following Benoit, this study seeks to further delineate the nature of mothers' internal representations and, following Ward (as well as Chatoor, 1989), these investigations of maternal representations will be used to focus on the quality of mothers' behavior with their children. As of yet, no research has added to Benoit's study by systematically evaluating the internal representations of mothers whose children are diagnosed with FTT and comparing them to mothers of normally eating and growing children as well as to mothers' interactions with their children and their child's FTT versus control status. Based on the previous research, there are three general research questions to be answered:

Research Question 1: What are the internal representations of mothers of FTT children like compared to mothers of controls?

Hypothesis #1a: Mothers of FTT children will have less access to their representations of object relations than control mothers.

Hypothesis # 1b: Mothers of FTT children will produce more uniform representations of object relations than control mothers.

Hypothesis #1c: Mothers of FTT children as compared to control mothers will show more qualitative failures in symbolizing.

Research Question 2: Does the behavioral interaction between an FTT child and mother differ from that of a control dyad?

Hypothesis #2a: Mothers of FTT children will be less sensitive and have less reciprocal interactions than mothers with their control children.

Research Question 3: Are internal representations of relationships meaningfully related to mother's behavior with her child as attachment and psychoanalytic theory would predict they would be?

Hypothesis #3a: Mothers who produce fewer representations of object relations will be less sensitive with their children.

Hypothesis #3b: Mothers who produce more uniform representations of object relations will be less sensitive with their children.

Hypothesis #3c: Mothers who are qualitatively less adept at symbolizing will be less sensitive with their children.

Chapter 2: Methods

This research was a between-group design comparing mothers of FTT children to mothers of controls as well as a correlational study of maternal psychological attributes and maternal behavior. The purpose of the design was to explore group differences between the FTT and control mothers on ratings of object representations and quality of symbolization and to relate these differences to the sensitivity of mothers' caregiving behavior and the child's control or FTT status.

Subjects

This research was an addition to a larger study investigating the psychobiology of stress in FTT carried out at New York Hospital-Cornell Medical Center (Ward, Polan & Lipper, 1991). Subjects for this study were 52 9- to 24-month-old children and their mothers. There were two groups of dyads; 28 normally growing children and their mothers and 24 FTT children and their mothers. Both groups were recruited from private outpatient services and pediatric clinics affiliated with New York Hospital and through neighborhood announcements and word of mouth (See Appendix A for a copy of the recruitment letter.)

Children were classified as FTT according to the following criteria: their weight was below the fifth percentile on National Center for Health Statistics (NCHS) growth charts or they were at least six months old and had experienced a deceleration in weight gain sufficient to bring their weight below the 10th percentile after passing two major percentile markers within a six-month period (i.e., weight-for-age decreased two or more standard devia-

tions) on NCHS charts (Ward, Polan & Lipper, 1991). In addition, by measuring bone age, careful attention was paid to excluding children who were not malnourished. Bone age can distinguish FTT from intrinsic short stature and constitutional delay in growth and development, both possible imitators of FTT (Schmitt & Muaro, 1989). In intrinsic short stature, bone age is greater than height-age, but equal to chronological age. In constitutional delay in growth, bone age is lower than chronological age but is usually equal to height-age, and both are most often greater than 75% of chronological age. In FTT, both bone age and weight-age are generally less than height-age. Children were also excluded who had neurological disorders, life-threatening or terminal illness, history of intrauterine growth retardation, endocrine disease, and premature birth (before 35 weeks). All control subjects were above the 10th percentile for weight and height on NCHS charts.

Permission for this study was granted by the Institutional Review Board at the Cornell Medical College. (See Appendix B for copy of IRB approval and consent forms.)

Measures

Rorschach:

The Rorschach test was chosen for its success in revealing aspects of the underlying personality organization of the subject (e.g., Diamond, Kaslow, Coonerty, & Blatt, 1990; Parker, 1983; Mayman, 1967; Rosenzweig, cited in Vernon, 1964). In comparison to self report measures, the Rorschach taps aspects of personality not observed by the subject and has the advantage of being viewed as generally less influenced by social desirability factors and therefore a 'cleaner', more accurate test (Vernon, 1964). Because the stimulus is ambiguous, subjects are unaware of how their responses will be interpreted and

are "much less on guard to display an acceptable personality than in self-report or behavioral tests" (Vernon, 1964). While at times criticized for "measuring a little bit of everything and not enough of anything to give dependable and quantifiable results"(Macfarlane & Tuddenham, quoted in Vernon, 1964, p. 174) recently developed scales focusing, in particular, on the assessment of object representations on the Rorschach have shown impressive connections between mental representations of self and other and personality functioning and psychopathology—data which enables researchers to assert that the Rorschach can be used to infer aspects of personality functioning (e.g., Blatt et al., 1976; Mayman, 1967; Tuber et al., 1989).

The standard administration of the Rorschach was used. Subjects were requested to state what they saw in each blot and, after each card had been responded to, to look at the cards again and state the qualities that made it look like what they saw. Upon receiving the first of ten cards, subjects were asked "What could this be?". All responses on Card I were followed by the prompt "What else could it be?". This prompt was discontinued during the remainder of the subjects' free responses to cards II–X. Inquiry for determinants (e.g., "what makes it look like a bat?") followed presentation of the entire series. There was one departure from standard procedure: During the inquiry, if the subject gave a movement response, e.g., "a squirrel crawling," the interviewer asked the open-ended question "crawling as if?" (Tuber, 1988). Rorschachs were administered by two trained doctoral students in clinical psychology and one trained doctoral student in developmental psychology all of whom were blind to the subjects' group membership.

The one known Rorschach study of an FTT population found no significant results (G. Alfosie, personal communication, April, 1992). This work tried to differentiate mothers' group status (control mother or mother of FTT

child) using Exner's (1986) broadly-based assessment system of personality functioning. The specificity of the present study's hypotheses as well as the poor results of the prior work necessitated drawing on a Rorschach scale which rates representations of object relationships.

The Mutuality of Autonomy Scale:

The Mutuality of Autonomy Scale (MOAS) (Urist, 1977; Urist & Shill, 1982) is a rating system for Rorschach responses which depicts relationships, even inanimate ones. The scale is designed to reveal qualitatively distinct and significant object representation paradigms and was used to assess mothers' internal representations of relationships. The scale refers to gradations in "the individual's capacity to experience the self and other as mutually autonomous within relationships" (Urist, 1977, p. 4). Relationships described in percepts are coded as falling into one of seven categories, the higher categories reflecting more maladaptive orientations to relationships: Scale Point 1: Figures are engaged with each other in such a way that suggests reciprocity; they are mutually involved and yet seen as distinctly separate and autonomous, e.g. "Two bears toasting each other, clinking glasses;" Scale Point 2: figures are engaged together in some form of parallel activity; "Two women doing their laundry;" Scale Point 3: Figures are seen as leaning on each other, or one figure is seen as leaning on the other, the sense is that objects do not stand on their own or that they require some external source for support; Scale Point 4: one figure is the reflection, or imprint of another, the relationship between objects is that one exists only in so far as it is the extension of another; Scale points 5, 6, 7, reflect gradations of increasing dominance, malevolence, and destruction: Scale Point 5: figures are seen in an unequal, imbalanced relationship, such as a one-sided battle or a situation of malevo-

lent control; Scale Point 6: figures are experiencing an overt attack or attempt at destruction by other figures, e.g., "a leech sucking up the blood from that man;" Scale Point 7: figures are victims of overwhelming, catastrophic malevolence and evil. A percept such as "two witches, they're laughing, as if sharing a secret about someone" would receive a rating of 1; the response "a violent God, up in the sky...The people are not to survive" would be scored a 6 (Urist & Shill, 1982; Tuber et al., 1989). (See Appendix C for a summary chart of the MOAS.)

Urist (1977) reported inter-rater reliability scores of .52 for exact agreement, .66 for agreement within one-half point, and .86 for agreement within one point. Other studies have listed reliability statistics for exact agreement as ranging from .58 to .90, and one point agreement from .72 to .98 (Stricker & Healey, 1990). Tuber (1989) summarized reliability data for MOAS as .70 to .90 for exact agreement, and reliability as consistently above .85 for one point differences.

To provide construct validity, Urist found significant correlations between the MOAS and autobiographical and staff ratings of in-patients ways of perceiving and interacting with others (Urist, 1977). He then replicated this study, this time using only excerpted Rorschach data to control for the possibility that information contained in the entire protocol (e.g., thought disorder, primitive aggressive and sexual content) was contaminating the MOAS ratings. Again, Urist found that MOAS assessments correlated significantly with independent clinical ratings of patients object relations functioning. However, a recent study contradicted this scale's construct validity. Researchers found that MOAS scores correlated significantly with independent assessments of clinical symptoms but not with independent assessments of interpersonal behavior (Blatt et al., 1990). The authors suggest that the

MOAS may be a better delineator of pathology than object relations. On the other hand, their research, while seeming to replicate Urist's procedure, utilized a less direct method of evaluating patients' object relations that may help account for the discrepancy in the results. In Urist's work, ward staff *directly* rated patients whereas in Blatt's et al.'s research summary scores of patient's interpersonal functioning were arrived at indirectly by two readers who culled through staff's notes about the patients. The immediate, visceral experience of one-to-one interactions was lost while confounding information was introduced such as the readability of handwriting and respect for one staff member's observational skills over another's.

Tuber and colleagues (Tuber et al., 1989) found that the mean MOAS scores for children just about to undergo surgery were significantly more malevolent as compared to a matched control group. In a study showing predictive validity, Tuber (1983) looked at MOAS ratings of children and related them to later need of psychiatric services. His results showed that children whose most benevolent object relation scores on the MOAS were in the more adaptive, benign range of the scale (1,2) were significantly less likely to require further hospitalization as adults whereas children who had more malevolent scores (5, 6, 7) were consistently more likely to require psychiatric hospitalization. In a comparative study of children diagnosed with Attention Deficit Hyperactivity Disorder (ADHD), some with ADHD and Borderline Personality Disorder (BPD), and some with ADHD and BPD, Thomas (1987) found that the modal MOA scale scores and the range of scores did not differentiate the groups. For all three groups the modal score was in the 5, 6 range and the total range of scores was between 1 and 6. However, in comparing the percentage of scores that were in the 1 to 2 range versus those in the malevo-

lent range, he found that for the borderline children a majority of their scores fell in the 1, 2 range but that this ratio was reversed for the other two groups.

In this study, two coders, clinical psychology graduate students blind to subject status trained to a reliability of 90% on protocols from another research project, coded the Rorschach protocols. These coders scored all of the protocols; 15 of the 52 protocols (29%) were scored independently by both raters. Kappa coefficients and percentage-of-agreement figures were computed between the two raters ($N=15$), $K= .64$, $SE = .04$; percentage of agreement = 81%.

The Transitional Object Scale:

The Rorschach Transitional Object Scale (TOS) (Greenberg et al., 1985; Cooper et al., 1985), as its name suggests, attempts to operationalize Winnicott's theory of transitional space. The TOS scale counts the number of times subjects' responses exhibit one of the five following features: (1) relating to one's percepts as real and comforting objects (e.g., "the two little koala bears are cute, they'd make great pets"); (2) treating colors on the cards as concrete objects (e.g., "the blue is peaceful"); (3) incorporating the actual cards into one's own experience, (e.g., "it looks like a bearskin rug, I have one at home"); (4) emphasis on the changing nature of the cards and/or their construction (e.g., references to who made the cards); and (5) treating the cards themselves as real objects (e.g., stroking it, throwing it) (Cooper et al., 1985).

In explaining this scale, the authors emphasize the quality of omnipotent object relating which Winnicott described as an early part of transitional space. According to Cooper and his colleagues, Winnicott

introduced the concept of transitional phenomena and defined the transitional object as a real object such as a teddy bear or a blanket that the infant believes exists because of the infant's need

for the object. The infant endows this familiar object with soothing and tension-relieving properties that he can utilize at times of maternal separation or at times when the mother is unable to provide needed soothing (Cooper et al., 1985, p. 116).

However, this emphasis on the omnipotent object-creating aspects of transitional experience overlooks Winnicott's ideas of how transitional object relating (including the omnipotent quality) is part of the development of transitional space and symbolization. They seem to miss how, according to Winnicott, the initial stages of omnipotent creating lead to the preservation of inner subjective experience that can co-exist with objective reality of knowing others as separate, whole objects. Winnicott's ideas of how flexible symbol use emerges from transitional object relations of transitional space are ignored. *That* blanket, in soothing the infant, is an experience in transitional space not only as an omnipotently-created reliever of tension but because the infant endows it with subjective, inner meaning while respecting its objective reality — it is a first symbol in potential space.

As the TOS scoring system examines one kind of object representation over the ability to move between subjective and objective experience, the scale only partially captures Winnicott's ideas about transitional objects. Although several authors using this scale have noted the qualities of "confusion of symbol and the object it represents" or the problem of "differing the symbol from the object symbolized" (Cooper et al., 1985, p. 120), and therefore have suggested how the scale could be used to assess the quality of transitional space and symbolization, none of them incorporate these ideas into the scale.

Cooper reports inter-rater reliability on each of the TOS criteria as ranging between 85% and 95%.

To provide construct validity, Cooper and his colleagues (Cooper et al., 1985) used the TOS to “determine the extent to which borderline and antisocial personality disorders are psychodynamically distinct” (Cooper et al., 1985, p. 118). They found that the TOS provides basic discrimination between borderline psychopathology and antisocial personality disorder. Cooper et al. compared groups based on the presence of transitional relatedness on the TOS. Using a chi-square test on a 2 X 2 table consisting of a median split on the TOS (median = one positive score per subject) they found that people with borderline personality disorder (BPD) were more likely to score positively on the TOS ($X^2 = 4.85$, $p = .02$, $n = 35$: 70% of people with BPD scored above the median compared to 33% of the subjects diagnosed with antisocial personality disorder).

In the present study, a modified version of the TOS was used in an attempt to more accurately operationalize Winnicott's ideas and assess the quality of mothers' representations seen in their use of symbolization on the Rorschach. It was hypothesized that some people would exhibit difficulties using the 'play space' of the Rorschach testing experience to move between objective and subjective experiences and see a blot from multiple perspectives as alternatively as a blot and 'as if' it's an angel. For example, overpowered by the reality pole, the ink blots are just ink blots and nothing more. Or, immersed in a subjective perspective a monster *is* there, and associations to it overtake the ability to think about it simultaneously as a card. The first kind of failure in symbolization suggests a constricted style, the second, a loss of distance as the subject's subjective view floods and overtakes external reality (Ogden, 1993). Thus, the TOS scale was used to distinguish percepts that evidence the symbol use deficits of a loss of distance and constriction. However, whereas the original TOS scale emphasizes the comforting quality of objects

seen, in this study that factor did not receive the same focus, for reasons described above. A percept on a card that is elaborated on or related to as if real therefore qualifies as a loss of distance response, even if the object that was seen as real is not necessarily comforting. (This does not appear to be such an alteration of Cooper's scoring system as in the manual under the specific category "treating objects as if they were real and comforting," he lists as an example "a hippo, he's facing you, I have the thought he's going to kill you, stomp all over your face"). Also, in contrast to the TOS, for this study the category "emphasis on the changing nature of the cards and/or their construction" was altered. Specifically, the manual lumps together the changing nature of cards and their construction as both suggesting loss of distance, whereas they seem to suggest two different ways of relating to the cards. Under the former, the manual lists as an example: "All this pink—a path through the tunnel—all of this pink has to funnel through, it's gotten half way so far (Card IX)." Here, as the manual suggests, the realness of the pink is evident, the subject's subjective reality is taking over and the pink path is real. There is a loss of distance. However, for the category construction of the cards, the manual lists as an example: "This is actually an ink blot? Or are you sure that someone didn't draw that?" In this latter example, an inability to phantasize, a defensiveness against playing with the cards seems evident. A category was also added denoting "an inability to list determinants that facilitate seeing the percept." In this instance, subjects refer to the percept as if it's real (losing distance) rather than being able to describe that it is, for example, the shape of the blot that makes it look like an elephant—showing an inability to move between objective and subjective experiences. Finally, a category was added for situations in which subjects seem to try to control their 'loss of distance' experiences by describing the blot as something close to what

it is, e.g., a mess, finger painting and a category was deleted which coded the interaction of the subject with the card. (See Appendix D for a copy of the amended TOS manual.)

Two coders, clinical psychology graduate students blind to subject status trained to a reliability of 90% on protocols from another research project, coded the Rorschach protocols. These coders scored all of the protocols; 15 of the 52 protocols (29%) were scored independently by both raters. Kappa coefficients and percentage-of-agreement figures were computed between the two raters ($N = 15$, $K = .17$, $SE = .05$; percentage agreement = 62%. However, because each Rorschach percept could receive a positive rating for each of the 14 TOS categories and yet the system of measuring reliability did not calculate all the times the raters agreed *not* to give the percept 1 of the 14 scores, the reliability score underestimates the true amount of agreement.

Observation scale for m-c interaction during feeding:

Videotapes of mother and child having lunch were analyzed using Chatoor and colleagues' (Chatoor, Menvielle, et al., 1988) scale. This scale has five overall factors by which to measure patterns of mother and child behavior during feeding: (1) dyadic reciprocity, (2) maternal noncontingency, (3) dyadic conflict, (4) bargaining for food, and (5) struggle for control. The scale uses a four-point Likert-type format for rating the behavior and affect of mother-child pairs from "none" to "very much." The scale has 26 items focusing on the mother and 20 focusing on the child, spread throughout the five categories. For example, dyadic reciprocity evaluates, among other items, if the mother "positions infant for reciprocal exchange" and if she "shows pleasure towards infant in gaze, voice or smile." This subscale looks at if the infant smiles at its mother. Maternal non-contingency assess if the mother

"handles the infant excessively" and "misses infant's cues." Dyadic conflict looks at if the mother makes negative or critical remarks to the infant and if the infant refuses to open its mouth. Bargaining about food examines the mother telling the infant to eat and whether or not the infant is easily distracted from the task of eating. Lastly, struggle for control assesses if the mother "controls feeding by overriding infant's cues" and if she "appears concerned about messiness" among other items. In developing the scale, items were retained only when there was at least 75% observer agreement and for which no one observer disagreed more than one ordered step in the categories response sequence. Chatoor reports that, in general, excellent group classification (FTT or normal) has been obtained for each of the five factors of the scale. Overall percentages of correct group classification range from 69 to 82% (Chatoor, Menvielle, et al., 1988). For this study, two observers trained to 85% agreement and blind to group classification scored the feeding video tapes using the Chatoor system. One-third of the tapes were conferenced with the principal investigator of the project, Dr. Mary Jo Ward.

Crittenden CARE coding scale:

Videotapes of mother and child interacting during a free play session were coded using Crittenden's (1983) measure of maternal sensitivity. This scale assesses several maternal and child qualities: facial expression, vocal expression, positions and body contact, expression of affection, pacing of turns, control, and choice of activity. On these seven qualities, mothers receive ratings that are then summed into classifying them as most prominently either (1) sensitive, (2) controlling, or (3) unresponsive. The infant's behavior on these seven qualities lend them to being characterized as primarily: (1) cooperative, (2) compulsive, (3) difficult, or (4) passive. In past research this system has recorded meaningful differences between maternal and child behavior of FTT

and control groups (Ward, Altman, Greenberg, Ona, Berkun, & Kessler, 1988) and securely and insecurely attached dyads (Ward & Carlson, 1995). In this study, one clinical psychology doctoral student and one master's level student coded the play video tapes. In order to obtain reliability data, Pearson correlations were computed for the three mother ratings used in this research; they are as follows: $r = .98$ for sensitive; $r = .97$ for control; $r = .93$ for unresponsive.

Demographics and measures of socio-emotional environment:

A questionnaire about recent life experiences was administered (Egeland & Deinard, 1975); the subject was read a list of 44 events (moved, recent death in family) and stated whether each event occurred in the last year. Total scores were based both on the frequency and severity of stressful events. An adaptation of Crockenberg's (1981) interview was next given in order to elicit information about how much help the mother received with the responsibilities of taking care of her children and who gave the help.

Procedures

Subjects were seen in offices and a playroom at New York Hospital's Child Development Department. On the first visit subjects completed a consent form and then were filmed for ten minutes by a hidden camera while they were instructed to "play as you would at home" in a room with age appropriate toys. (Throughout these sessions saliva samples were taken from the mother and child who voluntarily sucked on a cotton swab dipped in Kool-aid.) Next, demographic information was obtained and then the mother was filmed giving the child lunch, again instructed to "do as she would at home". Unlike the play sessions, the feedings lasted as long as the individual dyad wanted. The mother could choose to feed her child as she wished, using a high chair, seated at an age-appropriate table, etc. In the second visit, sched-

uled for one month later, cortisol samples were again obtained and the Rorschach Ink Blot Test, which was audio taped for transcription and coding, was administered. Controls were seen for two sessions and FTT dyads were followed for a year after the first two visits. Controls earned \$75 as compensation while FTT dyads were paid \$100. Research assistants blind to the subjects' control or experimental status conducted all procedures.

Chapter 3: Results

First a description of the sample will be provided then the results will be presented in the order of the three research questions: (1) group comparison of maternal representations; (2) group comparisons of maternal behavior with her child; (3) relations between mothers' internal representations and their behavior with their child.

Sample Description

The two groups were comparable on most demographic and social variables. Most mothers were married (61%) and had either one child only (the study child) or a total of two children (42.2% and 38.5% respectively). The mothers' average age was 28.6 years ($SD = 6.7$), their average level of education was 13.6 years ($SD = 2.8$). Although the average yearly household income varied dramatically, from \$3,000 to \$170,000, with the average at \$40,000, there were no significant group differences. Also, there was wide variability in the number of hours the study child was cared for by someone other than the mother—0 hours to 66 hours per week. The average amount of time was 14 hours of other-than-mother care and there were no significant group differences. There were no group differences on racial or ethnic background. Twenty-six percent of the mothers were African-American, 31% were Caucasian, 27% were Latina, 6% were Asian, and 10% were of other ethnic backgrounds. Twenty-nine percent of the fathers were African-American, 28% were Caucasian, 29% were Latino, 4% were Asian, and 10% were of other ethnic backgrounds. Mothers in both groups reported moderate levels of stress in their lives, such as the birth of their baby or a recent move, and more satisfactory support from families than husbands. However, there were

group differences on three variables: the control child was on average 3 months younger than the FTT study child, 18.5 months versus 15.5 months; $t(50) = 2.19, p = .033$ and mothers of FTT children reported significantly less support from friends and professionals than control mothers $t(49)=2.95, p=.005$ and $t(49)=2.20, p=.041$. Where necessary, these three variables were controlled for.

Group Comparisons of Maternal Representations

Following Tuber (Tuber et al., 1989), Kalter and Marsden's (1970) method for controlling for Rorschach productivity was used. For each subject, the total number of MOAS and TOS scores was subtracted from their total number of responses, e.g., Response Total - MOAS total. The resulting variable—in the example, response total without number of MOAS responses—was then compared to subjects' number of MOAS responses and explored as a variable that significantly distinguishes between the control and FTT groups (analysis of variance design.) No significant findings were found for either TOS or MOAS. These results suggest that Rorschach productivity did not significantly influence the patterning of the MOAS or TOS scores. No correction for Rorschach productivity was necessary.

MOAS:

Because the MOAS is ordinal scale (Tuber et al., 1989, Tuber, 1983), non-parametric statistics were used to analyze this data.

In order to compare FTT versus control mothers on the MOAS scale, subjects' modal score, single highest score (most malevolent), single lowest (most benevolent) summation of benevolent (1, 2's), summation of malevolent (5's, 6's, 7's), and summation of dependent, mirroring scores (3's and 4's) were calculated. In addition, the range of scores was calculated in order to ex-

amine how "uniform" a subjects responses were. A subject with a constricted (smaller) range is seen as giving very similar, uniform responses. The range was calculated by subtracting the highest from the lowest score for each subject. In order to assess mothers' access to their internal representations of object relations, the total number of MOAS scores was tallied for each subject and group comparisons were made. Results are presented in table 3.1a and 3.1b.

Table 3.1a Comparisons of Median MOAS Variables by Group

MOAS RATING^a	FTT	CONTROL
	Median	Median
Sum benevolent	4	4
Sum malevolent	0	6
Sum mirror/dep.	0	3
Single lowest	1	1
Single highest	3	6
Mode	2	2
Range	2	4

Note: N = 23 FTT, 27 Control except for Mode: N=14 FTT, 19 Control.

^aMOA scales have a range of 1 to 7, the higher the score, the more malevolent the object representation; see appendix for copy of manual.

Table 3.1b Means, Standard Deviations, and Comparisons of MOAS Variables by Group

MOAS RATING ^a	FTT		CONTROL		z ^b	p ^c
	X	SD	X	SD		
Sum benevolent	4.35	2.1	4.33	2.76	-1.67	.87
Sum malevolent	5.7	9.49	6.11	6.6	-1.23	.26
Sum mirror/dep.	2.35	3.54	3.52	3.46	-1.48	.14
Single lowest	1.39	.49	1.48	1.01	-.31	.75
Single highest	3.74	1.76	4.89	1.5	-2.35	.02*
Mode	2.36	1.45	2.9	1.6	-1.34	.18
Range	2.35	1.77	3.41	1.67	-2.06	.04*
Number of MOAS responses	4.48	2.27	4.67	2.17	-.51	.61

Note: N = 23 FTT, 27 Control except for Mode: N=14 FTT, 19 Control. ^aMOA scales have a range of 1 to 7, the higher the score, the more malevolent the object representation; see appendix for copy of manual. ^bMann-Whitney *U* test corrected for tied ranks and expressed as a normal deviate. ^cTwo-tailed tests.

Table 3.1a presents median MOAS scores by group. Table 3.1b presents mean MOAS scores by group and summarizes the results of group comparisons using the Mann-Whitney *U* test. There were no differences between FTT and control mothers on their average scores of summed benevolent, malevolent, or mirroring scores, nor on their single lowest and modal scores (both groups hovered around a score of 2) nor on their number of MOAS responses. However, there were significant differences between the groups on the range of MOAS scores and single highest scores. Control mothers' average range of scores was significantly greater than FTT mothers' and control mothers' had significantly higher highest (malevolent) scores compared to FTT mothers. When examined as median group scores, the contrasts between the two groups is even clearer.

TOS:

In order to compare groups on quality of symbolization, results on the TOS were tabulated. The TOS was scored by summing the number of times any of the criteria appeared on the Rorschach. Results are presented in Table 3.2. Although tabulation of the data in this way transformed it to interval data, the data distribution was markedly nonnormal so nonparametric statistics were used.

Table 3.2 Means, Standard Deviations, and Comparisons of TOS Variables by Group

TOS RATING ^a	FTT		CONTROL		z ^b	p ^c
	X	SD	X	SD		
Treats percept as real object	3.17	4.32	2.64	2.5	-.038	.97
Treats color as concrete object	.04	.20	.11	.32	-.875	.38
Percept justified by personal experience	1.04	2.14	1.4	1.5	-1.42	.16
Inability to list determinants	7.8	4.68	7.04	4.7	-.489	.63
Describes action used to make percept as if it's real	.17	.64	.29	.60	-1.23	.22
Describes feeling has in response to card	.42	.72	.14	.36	-1.45	.15
Use of personal pronoun with percept	d	d	.04	.19	-.925	.35
Reference to card themselves	.38	.82	.82	1.2	-1.9	.06
Reference to changing nature of percept, as if real	.13	.61	.12	.41	-.408	.68
Reference to change card to fit percept	.54	1.56	.43	1.34	-.263	.79
Contain loss of distance by see percept as close to what is	.67	1.2	1.07	1.35	-1.29	.19
Hold tester responsible for card	.04	.20	.04	.19	-.11	.91
Coop ^e	5.91	6.52	6.00	4.35	-.856	.39

Note: N = 24 FTT, 28 Control. ^aTOS scale; see copy of manual in appendix. ^bMann-Whitney *U* test corrected for tied ranks and expressed as a normal deviate. ^cTwo-tailed tests. ^dUnable to compute because all values are the same. ^eSummation of TOS scores following Cooper et al. (1985).

Table 3.2 presents mean TOS scores by group and summarizes the results of group comparisons using the Mann-Whitney *U* test. There were no significant differences on any of the TOS ratings although the variable "Reference to cards themselves" approached significance. Following Cooper (Cooper et al., 1985), subjects' rank on the total number of TOS scores ("Coop") was used

as a dependent variable in an analysis of variance. This test yielded no significant differences between groups ($F = .46$; NS). Next, following Cooper (Cooper et al., 1985), FTT versus control subjects were compared on the total number of TOS scores using a chi-square test on a 2 X 2 table consisting of a median split on the TOS (median = 4.5 positive scores per subject). No significant relationship between group status and TOS scores was found ($X^2 = .309$; NS). Fifty-four percent of the FTT group fell below the median on TOS scores while 54% of the control group scored above the median.

Group Comparisons of Maternal Behavior with Children

Group comparisons of dyadic behavioral interactions were compared. The CARE system, used to judge play interactions, yields scores attempting to isolate maternal behavior from the child's; the Chatoor scale, used to judge feeding interactions, assesses the dyad. The results are presented in Tables 3.3 and 3.4.

Table 3.3 Group Means and Standard Deviations of Mothers' Scores on the CARE Sensitivity Scale

CARE Scale ^a	FTT		Control	
	X	SD	X	SD
Sensitive	56.08	38.13	64.07	28.58
Controlling	32.64	35.08	22.11	21.46
Unresponsive	11.28	15.01	13.82	22.44
Overall Sensitivity	19.25	8.87	21.74	6.84

Note: ^aSensitive is the percentage of time the mother is judged to be acting in a sensitive way multiplied by 100; controlling is the percentage of time mother is judged to be acting in a controlling way multiplied by 100; unresponsive is the percentage of time mother is judged to be acting in an unresponsive way multiplied by 100; Overall sensitivity is a composite score of mother's behavior ratings that does not result in a percentage. It is reached by the equation $(\text{sensitive} \times 2) - (\text{control} + \text{unresponsive})$. N = 24 FTT, 27 Control.

As shown in Table 3.3, on average, control mothers earned higher sensitivity ratings, lower scores for controlling behavior, and higher overall sensitivity scores. However, control mothers also were judged to be more unresponsive (less responsive) with their children. Because children's age significantly correlated with maternal sensitivity ratings, the data was submitted to univariate analyses of covariance (ANCOVAs). In general, mothers' sensitivity scores showed significant main effects of group. Mothers of control children tended to earn higher sensitive scores $F(1, 48) = 3.022, p = .089$ and higher overall sensitivity scores $F(1, 48) = 3.775, p = .058$. Mothers of FTT children earned significantly higher scores for controlling behavior, $F(1, 48) = .321, p = .042$. There was no significant main effect of group for unresponsive behavior $F(1, 48) = .020, p = .887$.

Table 3.4 Group Means, Standard Deviations, and Comparison of Scores by Group on the Chatoor Feeding Scale

Chatoor Scale ^a	FTT		Control		t value ^b
	X	SD	X	SD	
Dyadic Reciprocity	34.56	6.52	38.22	7.33	1.88*
Noncontingency	4.08	2.87	3.07	2.55	1.32
Dyadic Conflict	10.44	7.54	6.64	7.50	1.79*
Bargaining about food	7.13	2.18	5.89	2.04	2.07*
Struggle for control	6.52	3.34	4.04	2.15	3.08**

Note: ^aEach category in the Chatoor scale is based on the assessment of mother and child behavior together. ^bOne-tailed *t* tests based on separate variance estimates. **p* ≤ .05 ***p* ≤ .01. N = FTT 23, Control, 28

Table 3.4 presents the results of group scores on the Chatoor scale. Mother-child dyads in which the child was FTT were judged, on average, to have less reciprocal interactions, more non-contingent responses as well as higher levels of dyadic conflict, bargaining for food, and struggles for control. As the results on this scale did not correlate with the child's age, the data was submitted to *t* tests. In general, one-tailed *t* tests comparing the two groups revealed that the FTT group had significantly higher dyadic conflict, bargaining for food, and struggle for control scores than the control group. A *t* test revealed that the control group earned significantly higher scores for dyadic reciprocity. There was no significant difference between the groups on non-contingent behavior.

Relations between Internal Representations and Mothers' Behavior with their Children

In order to examine relations between maternal representations and their behavior with their children, four analyses were done. The MOAS scores were related to the CARE and Chatoor scores and the TOS scores were related to the CARE and Chatoor scores. These results are presented in the following four tables.

Table 3.5 Correlations^a Between MOAS and CARE Scores

MOAS	CARE			
	Sensitive	Controlling	Unrespon- sive	Overall Sensitivity
Sum mir- ror/dep	-.13	.13	.04	-.13
Sum malevolent	-.07	.08	.02	-.07
Sum benevolent	.20†	-.20†	-.03	.22†
High	-.09	.08	.03	-.09
Low	.05	.01	-.09	.05
Range	-.09	.10	-.00	-.09
Mode	-.25†	.17	.14	-.28†
Number of MOAS resp.	.00	-.02	.03	.01

Note: ^a Spearman rank correlation coefficients. N = 51 or 49, depending on missing data; except "mode", N=32; Significance test, one-tailed:

† $p \leq .10$

* $p \leq .05$

** $p \leq .01$

*** $p \leq .001$

Table 3.6 Correlations^a Between MOAS and Chatoor Scores

MOAS	Chatoor				
	Bargain for food	dyadic conflict	struggle for control	non-contingency	dyadic reciprocity
Sum mirror/dep	.00	.02	-.10	-.15	.07
Sum malevolent	.01	-.12	-.21†	-.14	-.01
Sum benevolent	-.13	-.07	-.16	-.21†	.05
High	-.09	-.16	-.17	-.13	-.02
Low	-.02	.12	.05	.17	-.22†
Range	-.07	-.17	-.16	-.20†	.04
Mode	.19	.14	-.01	.18	.02
Total number of MOAS resp	.04	-.01	-.19†	-.27*	.07

Note: ^a Spearman rank correlation coefficients. N = 51 or 49, depending on missing data. N=32; Significance test, one-tailed:

† $p \leq .10$

* $p \leq .05$

** $p \leq .01$

*** $p \leq .001$

Table 3.7 Correlations^a Between TOS and CARE Scores

TOS	CARE			
	Sensitive	Controlling	Unresponsive	Overall sensitivity
Treats percept as real object	-.19†	.17	.03	-.18†
Treats color as concrete object	-.07	.07	.04	.06
Percept justified by personal experience	-.01	-.06	-.02	.02
Inability to list determinants	-.30*	.24*	.06	-.29*
Describes action used to make percept as if it's real	-.11	.19†	-.06	-.11
Describes feeling has in response to card	.04	-.14	.10	.06
Use of personal pronoun with percept	.05	.02	-.12	.05
Reference to card themselves	.13	.01	-.16	.12
Reference to changing nature of percept, as if real	-.01	.10	-.05	-.01
Reference to change card to fit percept	-.09	.13	-.07	-.07
Contain loss of distance by see percept as close to what is	-.03	-.02	.10	-.04
Hold tester responsible for card	-.17	.24*	-.17	-.17
Coop ^b	-.15	.14	-.02	-.14

Note: ^a Spearman rank correlation coefficients. N = 51 or 49, depending on missing data. N=32;

^b Summation of TOS following Cooper. Significance test, one-tailed:

† $p \leq .10$

* $p \leq .05$

** $p \leq .01$

*** $p \leq .001$

Table 3.8 Correlations^a Between TOS and Chatoor Scores

TOS	Chatoor				
	Bargain for food	Dyadic conflict	Struggle for control	Non contingency	Dyadic reciprocity
Treats percept as real object	.14	.10	-.05	-.10	-.17
Treats color as concrete object	-.03	.07	.19†	.10	-.08
Percept justified by personal experience	.10	-.03	-.03	-.11	-.08
Inability to list determinants	-.19†	.26*	.24*	.04	-.22†
Describes action used to make percept as if it's real	-.10	-.29*	-.21†	-.23*	.19†
Describes feeling has in response to card	.21†	-.01	-.02	-.20†	-.12
Use of personal pronoun with percept	.21†	.24*	.15	.21†	-.24*
Reference to card themselves	.04	-.08	-.11	-.07	.03
Reference to changing nature of percept, as if real	.17	.16	.25*	.16	-.22†
Reference to change card to fit percept	.09	.03	.05	-.06	.04
Contain loss of distance by see percept as close to what is	.23*	-.02	-.11	-.17	.10
Hold tester responsible for card	.21†	.15	-.01	-.07	-.02
Coop ^b	.13	.00	-.02	-.15	-.12

Note: ^a Spearman rank correlation coefficients. N = 51 or 49, depending on missing data. N=32;

^b Summation of TOS following Cooper. Significance test, one-tailed:

† $p \leq .10$

* $p \leq .05$

** $p \leq .01$

*** $p \leq .001$

In tables 3.5–3.8 some associations between mothers' internal representations and their behavior with their child are evidenced. Results from the MOAS showed that mothers' who had a greater number of benevolent representations tended to show more sensitive behavior with their child as well as less controlling behavior, both as judged by the CARE system during free play. Also, mothers with higher modal scores—that is, mothers whose modal scores hovered closer to the malevolent end of the spectrum—tended to show less sensitive care towards their child. Finally, mothers who had higher summations of malevolent scores and a greater range of scores tended to have *less* non-contingent behavior with their child and less struggling for control.

When related to the Chatoor scores from feeding interactions, the MOAS scores also showed some associations. Mothers who represented more malevolent scores (higher summations of malevolent scores) tended, in interaction, to struggle less for control with their children. Mothers who had higher summations of benevolent scores and those who had a greater range of scores (less uniform representations) showed a tendency to be judged as having less noncontingent (more contingent) behavior with their child. Higher single lowest scores was associated with less reciprocity and a greater number of MOAS scores (a greater number of Rorschach percepts depicting an interaction and thus able to be scored by this system) was found to be somewhat related to less controlling behavior and less noncontingent behavior (more contingent behavior).

When summed together, the TOS scores (denoted by "Coop") had no significant associations with the behavior scores. However, when examined as individual scores, the TOS scores had some significant associations with both the CARE and Chatoor results.

Treating the percept as if it is real had a tendency to be associated with less sensitive care and less overall sensitivity, as judged by the CARE system. An inability to list determinants was also significantly related to less sensitive care, more controlling behavior, and less overall sensitivity during free play. Describing the action needed to make the percept (as if the percept were real, e.g., "standing at the monster's feet and looking up his face looks like this") was somewhat associated with more controlling behavior.

The correlations between the TOS and Chatoor scores were similar to those between the TOS and CARE results, with some notable inconsistencies. Similar to the results on the TOS and CARE correlations, treating the color as if it's real was weakly associated with more controlling behavior during feeding as rated by the Chatoor scale. An inability to list determinants was related to more struggle for control and more conflicted interactions; it was somewhat associated with less reciprocal interactions, and, somewhat inconsistently, less bargaining during feeding. Also, describing the action needed to make the percept, unlike in the associations with the CARE scores, here was, overall, associated with more mutual interactions. Specifically, describing the action needed to make the percept was associated with less conflict, less non-contingency (more contingent interactions); there was also a tendency for it to be associated with less controlling behavior and more reciprocity during feeding. Explicitly stating a feeling in response to a card was somewhat associated with more bargaining during feeding and less noncontingency. Referring to the percept by a personal pronoun (e.g., "it's my fur rug") was weakly associated with more bargaining behavior and more noncontingent behavior while it was more strongly associated with more conflicted and less reciprocal behavior. Referring to the changing nature of the card as if it's real was related to more controlling behavior and less reciprocal behavior. Finally, trying to

contain a 'loss of distance' by seeing the card as close to what it is (e.g., "splattered paint") was associated with more bargaining behavior.

Chapter 4: Discussion

FTT, as a disorder with a complex etiology, is often susceptible to the influences of social construction. That is, depending on the current *zeitgeist*, or the *zeitgeist* of the group consulted (e.g., medical doctors versus psychoanalysts) failure to thrive is understood in different ways not often integrated. Against the current backdrops of a resurgence of neo-Kraepelin disease description and the ascendance of biological psychiatry's eschewing of psychological factors, this study followed attachment and psychoanalytic theories in attempting to demonstrate the role for psychological insight in contributing to the untangling of the intricate web of children failing to thrive. While not aiming to integrate the different paradigms for FTT nor advocate one over another, the results of this study support including consideration of the "emotional climate" between mother and child when approaching the development of FTT.

The Findings from the Study

In this study, mothers of FTT children differed on the dimension of internal object representations. As predicted, mothers of FTT children failed on the Rorschach, as scored according to the Mutuality of Autonomy Scale (MOAS), to represent self-other object representations at the more malevolent end of the spectrum. Their representations were also more uniform (having less of a range from the lowest low to the higher high) as a result of not having representations coded at the extreme end of the scale. For control mothers, their average (median) malevolent score on the MOAS scale of 1–7—the one-time most malevolent score they ever received—was a 6; for FTT mothers, it was only a 3. For control mothers, the range of their representa-

tions, their highest score for a malevolent percept minus their lowest score on the mutual–interaction end of the scale, was almost double FTT mothers'. To state it another way, FTT mothers' representations, on average, were void of any kind of imbalanced, aggressive experience. The groups did not differ significantly on their modal scores (for both groups the most common representation was of parallel interaction), their single most mutually–interactive representation, the summation of their scores for benevolent/mutual or malevolent representations, or their 'narcissistically oriented' representations.

Unlike previous studies that have shown more pathological representations—such as, more malevolent responses and group median scores in the malevolent range—differentiate boys who later will require hospitalization from those who won't (Tuber, 1983) as well as Gender Identity Disordered boys from controls (Tuber & Coates, 1989), in this study, as predicted, it was the access to a range of self–other representations including imbalanced, aggressive ones, which distinguished mothers of FTT children from mothers of controls.

This result suggest that the difference in mothers of FTT children versus mothers of controls is *not* their capacity to represent and/or access mutual or dependent interactions, their predominate mode of representing self and other in interactions, or an emphasis on malevolent interactions. What does distinguish the two groups is the range of representations, specifically, the capacity to represent or access representations of imbalanced interactions. It seems that mothers of failing to thrive children have less varied, more uniform representations of self and other while mothers of normally growing children have access to a wide range of representations of interactions, which includes some acknowledgment of non–mutual, domineering experiences.

For example, a control mother saw on Card II "Two china men playing patty cake;... like they're playing patty cake with their hands up against each other and sitting towards each other... just a game to pass the time" as well as, on Card IV, "an alien ... the smaller head and bigger body and big feet, it looks as if I were laying down, it would come stomp on me." On Card II a FTT mother also saw two people, "two people sitting down, just sitting and talking" but she then rejected Card IV—a card that lends itself to more malevolent precepts.

To further illustrate these results, here is a complete listing of the percepts given by a control mother and by a mother of an FTT child; note the intra-card and inter-card MOAS range of the control mother versus the FTT mother:

Control mother:

Card I: Two women dancing with capes; a butterfly.

Card II: People playing patty cake or something; the bottom looks like something flattened, like something run over.

Card III: Two women cooking; but all of them have this kind of, you know, like blood, like something run over.

Card IV: a monster.

Card V: a bat.

Card VI: a tiger you make a carpet out of; a horse.

Card VII: Two women gossiping; dancers.

Card VIII: Two bears climbing up a mountain; a reflection of an animal.

Card IX: A reflection again; kind of ghoulish characters sticking out tongues.

Card X: creepy, crawly bugs; crabs

FTT mother:

Card I: a bat, a butterfly, two birds hanging onto something.

Card II: two elephants kissing; two puppies, making bubbles.

Card III: two kids holding onto a bowl.

Card IV: puppy dogs hiding behind a tree and kissing.

Card V: a butterfly; some sort of insect.

Card VI: bug with a big tail.

Card VII: two ballerinas kissing each other.

Card VIII: Two bears climbing a tree.

Card IX: a map.

Card X: scorpion, crabs, sea animals, sea horses.

The Rorschach responses for both these mothers contain percepts of harmonious, mutual interactions. However, the control mother is open to experiencing and/or able to represent her more malevolent associations to the cards while the FTT mother seems to practically "white wash" the cards so it is as if nothing in them stirs in her aggressive representations. Indeed, on Card X, during the inquiry, the FTT mother adds that she sees jellyfish "where it's splattered;" it is as if on some level she is reacting to the "splattered" quality of the blots but unable to allow that word/image to trigger in her anything and instead focuses concretely on it as a feature of the blot.

This finding of differences in the range of internal representations is consistent with the hypothesis offered by Fraiberg (1995) and Fonagy (Fonagy et al., 1993) that FTT mothers have difficulty accessing and/or representing internal self–other affective experience, particularly of a negatively–affectively charged nature. It is also consistent with the work of Benoit and colleagues (Benoit et al. 1989) who found mothers of FTT children to be rated insecure

on the Adult Attachment Interview's (AAI's) assessment of internal object representations. Mothers of FTT children produce object representations on the Rorschach that are unidimensional, just as they show heightened idealization (or an immersion in anger) on the AAI; They do not represent the spectrum of interactions (positive and negative) just as they do not show an integration of these experiences on the AAI. Furthermore, this study added to Benoit's understanding of the "incoherencies and inadequacies" of FTT mothers' inner representational worlds with respect to their management of aggressively-charged representations. Either these mothers are unable to represent these interactions or internal processes, such as defenses, block their access to them—all seen in this study—or they get caught on them, as seen in Benoit's work when many of the mothers of FTT were classified as "preoccupied" based on their moments of unintegrated anger with respect to past attachment relationships.

The use of a psychoanalytic perspective, in addition to the attachment paradigm, facilitates seeing the significance of offering an inner representational world devoid of imbalanced-aggressive interactions. As psychoanalysis posits that internalized representations of self and other are based on veridical representations of interactions with others (the emphasis in the AAI model) as well as on *the manner in which these experiences get organized under the influences of drives and phantasies*, it makes the "norm" the existence of some imbalanced, aggressive representations in everyone and puts in relief the person devoid of any. The emphasis becomes not primarily the content of these varied representations as reflections of lived experience, but what one does with one's inner representations, how they are managed intrapsychically (subjected to massive defenses?) and interpersonally. Furthermore, as psychoanalysis views the inner world as populated with

numerous and divergent self–other representations (as opposed to one primary Working Model of Attachment), it contributes to the expectation of varied internal representations, again shining the spot light on the person offering uniform representations.

It is possible, however, to interpret these results in an alternative way. In particular, the experience of having a sick child is, of course, dramatically impacting on mothers of FTT children in ways that perhaps are being manifested in their mental representations. While Benoit's findings (Benoit et al., 1989) of insecure attachment in mothers of FTT children versus *secure attachment in mothers with hospitalized children* suggests that qualities in mothers' representations play a contributing role to FTT and are not primarily a by–product of having a sick child, more definitive answers regarding the significance of maternal representations to FTT will have to await further studies.

In order to relate these significant group differences in maternal representation to the child's FTT or control status, group comparisons were first made between mother–child behavior interactions. Videotapes of mother and child interacting during free play and feedings were coded using the CARE and Chatoor systems which examine maternal and child qualities in the context of the other's behavior. As predicted, the results showed significant group differences on behavioral interactions between control and FTT dyads. Mothers of FTT children tended to provide less sensitive care to their children and were found to be significantly more controlling of them during free play. FTT dyads had significantly higher levels of dyadic conflict, bargaining for food, and struggle for control during feedings than control dyads. In contrast, control dyads earned significantly higher scores for dyadic reciprocity. These results replicate Ward's (Ward et al., 1993) and Chatoor's (1989) findings show-

ing that FTT mothers were rated as having less sensitive and mutual interactions compared to controls.

Next, an examination of the relations between internal representation, dyadic behavior, and FTT/control status produced mixed results. The kinds of internal representations which distinguished the control from the FTT group (more malevolent one-time scores and a greater range of representations) were not related to the behaviors which differentiated the two groups (e.g., more controlling behavior during feeding).

Furthermore, overall there were primarily weak associations between the ways mothers internally represented self-other relations and how they treated and interacted with their child as well as between the quality of representation in general (symbolizing) and behavior. However, as suggested by the addition of a psychoanalytic perspective on object representations, the MOAS results indicated that while higher levels of benevolent representations were associated with sensitive care, access to and/or a capacity to represent a greater number of malevolent interactions and have a range of representations tended to be associated *not* with more controlling and noncontingent behavior but with *less*. Also, the more MOAS responses on the Rorschach—again, the greater the capacity to represent and/or access internal object relations matrices, the less controlling and the more contingent the behavior in interaction tended to be.

In general, the assessment of symbolizing qualities as examined through the Transitional Object Scale (TOS) tended also to show only weak associations between difficulties in transitional space (that is, difficulties moving between a subjective experience of the ink blot and the objective reality of the blot) and mutual interactions where one's self and the other's experiences are genuinely attended to.

First, to illustrate more specifically the aspects of Rorschach responses being assessed by the TOS and associated with mother-child interactions, some examples will be provided.

In describing the following Rorschach percepts, these mothers offer something alive to them, they are 'playing with' the card and immersed in their subjective responses to it, but seemingly unable to balance this with specifics about the realities of the card:

Card II:

A volcano. All of this looks like the volcano and then this looks like something kind of stuff coming out of the volcano like fire shooting out of the top of it. (What makes it look like a volcano?) The fire shooting about.

Card IV:

A monster that's it. That's too ugly. Yeah, that's it, I don't see no more. (Can you show me where the monster is?) O.k., two big feet, and the long tail, nail, whatever, tail I think, and two short arms and the little head. (What makes it look like a monster?) I don't know, he's ugly. (Anything else about it that makes it look like a monster?) Yeah, have like things they get inside the skin (inside?) no, over here like bumps.

Card IV:

Looks like an alien or something. (What made it look like an alien?) I don't know because it has claws. Something you would see in a comic book or something, been reading too many of my brother's, the smaller head and bigger body and big feet at that angle it looks like it is coming towards you. (Coming towards you as if?) Like if I was lying down. Actually, it looks like if I was lying down it would stomp on me.

Card IV:

A tree. This is the trunk, these are the long branches that hang over the trunk, here is the top of the tree, these are just branches that branched out. (What makes it look like that tree?) The branches, the branches make it look like a tree.

These above responses would be coded for the percept seeming to be real to the subject and for an inability to list or describe the determinants of the card that helped them see what they saw. In the next two examples, the mothers offer percepts in which they not only want to change the card to fit

their subjective images but fare even less well at balancing what they see and respect for the realities of the blot; descriptions of both the percepts have the feel of the mothers being very much lost in their own internal experiences:

Card VI:

I don't know, looks like a bug. I guess this part right here. (What makes it look like a bug?) Those things down here, I don't know what you call them, the head. Little tiny two eyes over there and the little feet in the bottom you could see, and what else, hmmm, little feet over here, just cut these things out, well, I don't know. Really long legs. This part is, I don't know, extra little feet here, this part you could cut out.

Card I:

It could be a snowflake. Yeah, a snowflake, o.k., snowflakes, I was reading once about snowflakes and about how the crystals form, but you just feel, they're kind of like a glump, but if you really were to like scrape them or put them in your hand you could see they had all kinds of little shapes, they're no two snowflakes alike. (Where is the snowflake?) I mean the whole entire thing would be a snowflake but of course it would be white. (What makes it look like a snowflake?) Well, it doesn't really look like a snowflake, unless I mean if you put a snowflake under a microscope and then it could be a snowflake. Sometimes things can be things that they don't appear to be.

Compare all of the above responses with the following ones:

Card II:

It looks like two people fighting. Well, their hands um, and their feet. (What makes it look like they're fighting?) The way their hands were, the positions of their bodies, first of all. And then also the splatter, the splattering of the paint kind of reminded me of some kind of violence or something, so. (Two people fighting as if?) Um, I thought about a boxing ring, as if they were in a boxing ring.

Card IV:

It could also be just a costume. ... (Where?) It looks like costume here, this is the stand that it is on. This long line here is the zipper, and this is just pieces of material that's just in different lengths that's sewed on. This is the arms to the costume. The way it's shaped makes it look like the costume.

Card IV:

Looks like a gremlin or a troll or something. (What makes it look like a troll?) Well, he has these big feet, and sort of hooks for hands that are out of proportion to the body. And the big feet. Kind of imposing, looking down on

you. (What makes it look imposing?) Looking down on you. It definitely has a kind of malignant feeling about it. It does not look like a friendly creature. (Anything about the blot that makes it look malignant?) Um, the darkness, and the very small head and the sort of dark are where the eyes are. Malevolent is the word. (What makes it look like hooks for hands?) Just the shape of them.

Card V:

(After seeing Dracula on Card IV.) Mmmmm, Dracula turned into a bat to fly away. (Can you show me where?) He's turning. His legs are getting shorter, his face is getting smaller, His wings are getting—his cape is turned into wings, and his wings come out to fly away, so now he's a bat, and he's black. That means dark black. (To fly away as if?) He's gonna go far, I don't know, I guess far away. (What made it look like Dracula turning into a bat?) The cape, the shape.

Card VII:

Big clouds. Like clouds coming in like a storm is coming in or something. (Coming in as if?) Ready to rain, like it's tense like, like bad weather, very gray outside. (What made it look like big clouds?) The way it's connected, it looks like this is darker like right here, like when clouds come in together, when you can see a storm is coming.

Card X:

People parachuting. Yup. There's his legs, there's his parachute. And this is somebody else's parachute, like that. The person's out of the picture but this is their parachute. (And what makes it look like parachuting?) The bright colors and way it goes up and looks like his little legs. (And these people are parachuting as if?) As if they jumped out of a plane.

On all of these responses, the subjects too seem to be able to become immersed in and 'play with' the card so that what they describe is enlivened. On the other hand, unlike the previously discussed percepts, these ones are given with more balance: while what is seen is vivid and alive and 'real,' the objectively seen attributes of the card are also described. In these percepts, the subjects show that they can move between a subjective experience of the card and an objective one.

To make another comparison, the following percepts illustrates an overall constricted quality that suggests the mothers were unable to play with the

card. Nothing is enlivened in their response but instead exemplifies Ogden's (1993) second symbolization failure of the reality pole taking over:

Card VI:

This looks like the skin off some animal, like a raccoon or something.. When you see the skin of an animal it's sort of roughly, it's symmetric like this, and it's roughly, you see some outpouchings where there were limbs, you know, like front leg, back leg, roughly, and there's an overall—I mean I have to ignore this part, ... and there's no real head, and it just looks like part of, you know the outline of the skin of an animal.

Card VIII:

This looks like one of those fossils trivolites or something. Did you ever take paleontology? It looks just like a trivolite. They're odd animals. They became extinct a billion years ago or something, but they have a head sort of like this. I don't know if you could call them a head. Their body is roughly shaped like this, shaped like this where it's kind of triangular in the front and the back is rounded, and they have sections. They're one of the very primitive animals and they have sections. See how this has sections? (So, if I ask what makes it look like a trivolite?) The sections and the overall shape is sort of a triangular front and rounded back... the different colors and the fact that they're kind of separated too gives you the impression they have sections.

A higher incidence of immersion in a subjective experience, as in seeing the Rorschach percept as real or the color of the card as real exemplified in the first two groups of responses cited above, tended to be associated with less sensitive and more controlling behavior. Also, the inability to list determinants, the inability to move between what is subjectively seen and the objective attributes of the card, was also somewhat related to less sensitive and more controlling behavior, as well as more conflicted and less reciprocal interactions. In addition, being immersed in seeing the card as real and changing (again, a difficulty moving away from a subjective perspective and into an objective one—moving in the dialectic which makes up transitional space and is part of the process of symbolization) tended to be somewhat associated with more controlling behavior. Although marginal, these findings are con-

sistent with Chatoor's (1989) description of the most salient features of feeding-disturbed dyads, mothers' lack of mirroring and seeming inability to respond to their infants' cues: a mother immersed in her subjective experience may not attune (Stern, 1985) well enough to her child, insufficiently hearing and mirroring his or her subjective experience as it is outside of her own.

There was an interesting exception to the trend of deficiencies in symbolizing (or higher TOS scores) being associated with less mutual interactions: a higher incidence of immersion in the subjective experience of the card (specifically describing the action needed to make the percept as if the percept were real) was somewhat associated with more harmonious, less conflicted interaction during feeding but was associated with the opposite behavior during play. Perhaps the capacity to be immersed in a subjective experience, if it involves an identification with the baby's subjective experience, "can work" for feeding while the more dialogic quality of play requires movement between subjective and objective perspectives; hence, this kind of immersion seen on the TOS rating of Rorschach responses would work for the demands of feeding but not for those of free play. Since all other incidences of positive scores on the TOS were associated with less mutual interaction, it may also be that what is needed is a balance, a balance between subjective and objective perspectives with one's child, a balance between immersion in the subjective experience of the Rorschach and seeing its objective qualities at other times—this being truest to Winnicott's idea of transitional space, transitioning in between, the dialectic between, subjective and objective experiences. Unfortunately, as used in this study, the TOS was not configured to allow for such an exploration of a ratio of subjective immersion to an objective perspective on the cards.

This study lends some support to the hypothesis that looking at Rorschach responses as a process of movement between subjective and objective experiences, assessing the descriptions of percepts as examples of manifesting attributes of transitional space, can potentially illuminate aspects of people's capacities to relate to others in less and more narcissistically oriented ways. The individual variables of the TOS, as variables that assessed qualities of mothers' representations, their ability to be in transitional space as a "place" moving easily between subjective and objective experience, showed some significant associations with their behavior with their child. These findings, albeit somewhat weak, resemble the results found in Slade's (1986) study showing associations between the flexibility of symbolic play and the development of self and other representations. They also both conform to and are supported by the psychoanalytic perspective that sees symbolizing processes, as a mode of representational capacities, as reflecting the quality of object relations (Winnicott, 1971; Ogden, 1993). More specifically, the results can be viewed as consistent with Ogden's (1993) delineation of failures in symbolizing as they reflect failures in transitional space seen in difficulties maintaining a psychological dialectical process of multiple perspectives including inner and external realities, subjective, phantasy and objective realities, and distinct self and other view points. For example, instances in which private, subjective meaning took over on the Rorschach (Ogden's first example of symbolic weakness), such as when the percept was seen as real or when the subject could not move between their subjective experience of the card and the card's attributes, were associated with less mutual interactions. As Bach (1980) would put it, these results suggest that these are people who have difficulty moving between a subjective sense of self and an objective view of self, between their experience and another's, and this difficulty is mirrored in their symboliza-

tion deficits. In general, the correlations between symbolizing qualities and mother–child interaction, give qualified support to psychoanalytic theory and the fruitfulness of looking at *how* someone communicates as well as the content of the communication and indicate that the TOS may be a useful tool for future research.

On a speculative note, as one of the kinds of symbolization failures noted by Ogden is "a psychosomatic foreclosure on meaning" (Ogden, 1993, p.102) in which emotional arousal and experience are expressed directly through the body, bypassing the usual chain of symbolic, associative links (McDougall, 1989), and FTT children have a somatic disorder, it is useful to wonder about this connection. Might the symbol deficits in mothers indicate that they have the tendency to express themselves through their bodies, particularly given that they seem to have difficulty representing, and hence, by extension, perhaps experiencing aggressive interactions? If these mothers are closed–off to certain affectively–charged experiences, are they unable to help their children modulate and express such experiences, leaving them to express through their bodies what they themselves know no words for?

Overall however, this study produced relatively poor results regarding associations between the content of mothers' mental representations of self and other and representational quality (as judged by the MOAS and TOS scales) and their behavioral interactions with her children. As such, these findings seem to lend only minimal support to the attachment and psychoanalytic notions of the influence of inner representational experience on external, interpersonal behavior. However, these weak results can also be understood as, in part, a function of the bi–directional complexity of the mother–child relationship. Current models depict the mother and child contributing to the quality of the interaction (Beebe, Jaffe, & Lachman, 1992)—perhaps more so

when the child is sick—while the instruments used in this study attempted to isolate and measure the mother's behavior and relate it to her mental representations. There are two related fallacies: Thinking that the mother's behavior can ever be viewed without the influence of her child's and envisioning that one person's mental representations (even granting her a relative position of 'strength', given her extensive emotional history compared to her child's) will account for much of the statistical variance in an on-going, dynamic interaction. Thus, what is observed and seen as important in clinical work (e.g., Fraiberg, Rank) may not reach statistical significance in research, not because it is unimportant, but because most research, particularly as conceptualized in this study, measures human processing and interaction as if they were linear and/or static events.

The study also failed to find group differences between the number of internal object representations produced by mothers of FTT children versus mothers of controls. Hence, contradicting predictions, access to internal object representations, as measured by the number of Rorschach responses that qualified for MOAS scores, did not differentiate the two groups. This finding suggests that it is not access to representations or representations per se which might contribute to disordered mother-child interactions and the child failing to thrive; instead, what seems to have the potential of being more central is the question of what does or doesn't get represented, to which representations does or doesn't the person have access? On the other hand, the fact the both groups had relatively few MOAS responses—for both groups the average number of codeable responses was between 4 and 5—raises the possibility that the data is unrepresentative, particularly for the control group. Given that clinical thinking, as described by Fraiberg (1995) and attachment theory, as discussed by Benoit (Benoit et al., 1989) converge in noting an inability to ac-

cess inner experience and little memory for attachment, it seems reasonable to state that this hypothesis warrants further investigation.

Furthermore, the study failed to find group differences between the ways mothers of FTT children and mothers of controls symbolize. There were no group differences on how these women handled the dialectical process of moving between subjective and objective experiences on a Rorschach test as judged by the TOS. This finding, refuting one of this study's hypotheses, can have several implications. For one, it suggests that differences in the ease with transitional space is not a useful way to understand qualities of the mother that may contribute to her child failing to thrive. Another possibility is to look at weaknesses in the instrument itself. As noted previously, the TOS—even as amended for this study—may fail to pick-up on an inherent characteristic of successful use of transitional space, the by-definition necessary quality of needing to "fail" as well as succeed at it. That is, a measurement constructed to assess Winnicott's notions of transitional space would need to account for a balance between a loss of distance, an immersion in subjective experience, to the detriment of considering an objective perspective (the failures), as well as, at other instances, an adherence to reality, with the loss the capacity for a subjective/phantasy experience. In essence, the scale would need to assess the capacity for *within* percept movement between subjective and objective perspectives as well as the *between* percept, or overall balance of, precepts that qualify as "loss of distance" in subjective experience and those that suggest more of a reliance on the objective, external reality aspects of the Rorschach card. Not only would such an approach more accurately fit Winnicott's ideas, but it would also be consistent with other theory and current research suggesting that the capacity to "play with" and access a purely subjective perspective while also being able to move to an objective

view or have a "metacognitive capacity" allows for intrapsychic fluidity and richer life experiences (Bach, 1985; Main, 1991; Frank et al., 1994; Loewald, 1971).

This study's other significant failure was the finding that the kinds of internal representations which distinguished the control from the FTT group (more malevolent one-time percepts and a greater range of representations) were unrelated to the behaviors which differentiated the two groups (e.g., more controlling behavior during feeding). These null results suggest that the significance for FTT of having mothers who do not represent malevolent interactions and have more uniform representations is not conveyed via insensitive and controlling caregiving as judged by the CARE and Chatoor systems. Thus, it can be asserted that this study failed to capture the specific ways in which mothers having less malevolent representations and more uniform representations *matter* to their child's development of FTT. Moreover, by failing to designate specific pathways through which this increased knowledge about "the incoherencies and inadequacies" of mothers' internal representations affects the FTT child, it seems that this work failed to an extent in contributing to an explanatory model for FTT. There are three ways to consider this failure: either the significant group differences in mothers' MOAS scores are an artifact of the data and are not meaningfully associated with FTT in children; there is an undetected intervening variable (conduit) between the MOAS findings and the child's FTT status; or, the influence of mother's internal representations on the child's FTT status is transmitted via qualities in behavioral interactions not detected by the CARE or Chatoor scales. It is impossible to refute the first two explanations. Only further research will be able to confirm either hypothesis. However, the third explanation can be accounted for in ways that are consistent with other research and theory as well

as the overarching hypothesis of this study—that mothers' internal representations are playing a role in the child's failing to thrive.

In order to make this argument, it is necessary to return to clinical descriptions of failure to thrive. Recall Rank's (Rank et al., 1948) case of Betty, a three-and-a-half-year-old girl who was brought to treatment due to "extreme and increasing temper tantrums, destructiveness, fears, and nightmares which her mother immediately ascribed to her own prolonged conflict with Betty over food" (Rank et al., 1948, p. 279). Since she was 9-months-old, Betty had been on a highly restrictive diet due to celiac disease. This diet seems to have initiated a struggle between mother and child; the child often felt deprived and tried to sneak food. The mother would alternatively enforce the food restrictions over-zealously or give in abruptly, which would cause Betty to gorge and ultimately get sick. While a rigid diet is hard for any mother and child to manage, it proved to be pathogenic for Betty and her mother in part due to Betty's mother's history and resulting emotional conflicts around abundance and deprivation. Betty's mother had grown up in emotionally and financially bleak circumstances. Remembering her own starvation, she said "refusing a child begging for food is the worst thing possible" (Rank et al., 1948, p. 280).

And another clinical example: Billy, five months old, vomited after each meal and had not gained weight for three months. At birth, he had been a full-term, healthy baby, whose weight of 8 pounds put him in the 70th percentile on growth charts. At five months, he weighed only 14 pounds 5 ounces, which placed him in the 25th percentile. He had become a tense, morose, somber baby who looked 'like a little old man.' Even though he could crawl, he rarely approached his mother or even made eye contact with her. If Billy fussed, his mother put him to bed with a pacifier coated in honey. When

it was time to feed him, Billy's mother would place a bottle on the floor, several feet away from Billy, who would then crawl the long distance to reach it. Often he had to struggle to get the nipple in his mouth, but once he did, he would suck solemnly yet greedily. Billy's mother reported "He likes it that way. He likes to have his bottle, alone, on the floor" (Fraiberg, 1995).

It is likely that the kinds of dyadic interactions in both these clinical vignettes would be judged as insensitive, non-contingent, and also, perhaps, controlling. However, if these mothers also were to be found to have internal representations devoid of imbalanced self-other interactions and overall, uniform representations, it may be that the significance of this uniform quality in their representations is still not conveyed to the child via observably insensitive caring as measured by the CARE and Chatoor scales. How then might mothers' constricted range of inner experience be operative in her child's failing to thrive? I will offer two hypotheses.

According to modern Kleinian theory, when a mother is cut-off from the range of her own inner experience she cannot be optimally responsive to the extremes in her child's experience. In the words of O'Shaughnessey, such a mother deprives her infant of "a fundamental need for an object unlike himself which does not evacuate the unpleasurable, but instead retains it and thinks about it" (O'Shaughnessey, 1981, p. 179). This kind of non 'thinking about' or non-responsivity might not be measurable by gross signs of facial and vocal expression used in the CARE and Chatoor systems as it probably is conveyed through more subtle changes in mother's body tone, body rhythm, voice, and face. Furthermore, this non-responsivity most likely occurs during moments of heightened affect—the extreme ranges of experience. Play is less likely to encompass such experiences and feeding that has become a ritualized struggle (as seen in the laboratory) may not either. The CARE and

Chatoor scales, are, in essence, coding an agreed upon, anticipated dysynchrony, where as the "non responsive" interactions suggested by mothers' uniform internal representations may happen in moments of surprising let down. Alternatively, the havoc wrought by repeated experiences of emotional non-responsivity may have already sculpted the dyad into a pattern of exchanges which have influenced the baby to change his or her behavior to protect him or herself from these emotional falls. It is possible to hypothesize that a child who *feels* psychically left with his or her own intolerable feelings, adopts, like his or her non-responsive mother, a maladaptive means of emotional self-regulation. The roller coaster of hunger pangs and satiation, despair and elation, can not be satisfactorily managed. Food is ultimately not accepted, like the mother who doesn't accept her emotions. In the clinical example described above, Billy's mother negates his fussiness with a pacifier and honey just as she perhaps is unable to tolerate her own fussy feelings; he attempts to regulate himself by vomiting and she, perhaps, regulates herself by inhabiting a constricted range of emotional experience.

This interpretation—in the absence of a statistically robust connection between differences in mothers' internal representations and differences in their behavior with their children—is consistent with psychoanalytic theory, as already demonstrated, as well as developmental theories about emotion regulation (Fox, 1994). In the latter, there is the idea that the mother's open acceptance of many emotions is associated with her child's favorable development (as judged by the criteria of attachment security (Cassidy, 1994). Furthermore, when the mother has room for a range of emotions she does not suppress the child's negative affect, but is able to engage the child during times of anger and sadness to help the child constructively deal with such experiences (Tomkins, 1962, 1963). Finally, this body of literature also heralds

the ability to "think and talk about emotions" as one important dimension of self-regulation (Cole, Michel, O'Donnell Teti, 1994; Dawson, 1994). As researchers in this field put it "the ability to conceptualize emotion experience facilitates the self-reflective process and enhances self-regulation" (Cole et al., 1994, p. 89). The significance for the failing to thrive child of their mothers' inability to represent/conceptualize/verbalize the extremes of emotion experience may be there although undetected by the behavioral measures used in this study.

The second hypothesis involves the concept of enactment. As was described in Chapter One in the clinical descriptions by Casement (1985) and Altman (1992) it is well established in clinical settings that self-other experiences which cannot be accessed through verbal self-reflection (that metacognitive capacity) are often played out between patient and therapist. Such 'playing out' serves the function of communicating inner experience and through repetition, maintaining awareness of it in action. The often intense emotional swings of feeding experiences *for mother* as well as children might lend themselves to such enactments. To have a constricted range of self-other representations which omits malevolent interactions is to perhaps enact such experiences during the give and take of feedings. Is Billy's mother enacting with her child her own experiences of emotional abandonment as well as her cut-off rage and need to protect herself through domination? Could Betty's mother be understood as recreating with her child struggles similar to those that she experienced with her mother? Does Betty's mother revisit with her child her own painful childhood experiences, at times playing the other who relieves Betty of her deprivation (an acting out of her own childhood wish for rescue?) at other times becoming the denying other and inflicting on Betty the wretchedness she once felt?

Such an interpretation is consistent with both attachment and psychoanalytic research and theory. From the attachment paradigm, conceptualizing this kind of process between a mother and her failing to thrive child is consistent with Benoit's work (Benoit et al., 1989) in which she asserts that insecurely attached mothers of FTT children have relationships with their infants organized by themes of rejection, role reversal, and fear. Benoit sees such mothers as having "aberrant interpretations and subjective experiences" (1989, p. 196) of their infants which fit these clinical descriptions and coincide with the notion of reversing roles and looking to the infant as if her or she were the adult.

It is, however, the ideas from psychoanalytic theory which show most powerfully the usefulness of the concepts of enactment and role reversal, and make sense of the clinical descriptions. Psychoanalysis' emphasis on multiple internal representations of self and other, non-veridical internal representations, processes of defense such as projection suggest how and why internal experiences can become enacted. In these examples, the mothers' inability to access and/or represent painful self-other representations of non-mutual, imbalanced experiences, which co-exist along with other positive internal representations, contributes to her projecting a part of the experience into her child and expressing the self-other experience in action between them. In such a situation, the mother is seeing her child inaccurately, as the embodiment of projected internal representation, and perhaps contributing to her child's FTT by reliving with them her "ghosts from the nursery."

Although these two explanations are internally consistent as well as conform with attachment and psychoanalytic theories, clinical material, and, most importantly, the results of this study, they do not definitively answer this study's failure to link group differences in maternal representation with

group differences in dyadic interaction. Such an answer will have to await further research.

Implications of the Study

The present study comparing mothers of FTT children with mothers of controls along dimensions of internal representation and behavioral interaction has several implications for theory, research, and the treatment of failure to thrive.

First, by integrating attachment and psychoanalytic theories, particularly as they share a common ground in seeing overt behavior as meaningfully related to unconscious representational schemas focused on relationships, this study makes a contribution to the growing body of work integrating the two independent but related theoretical orientations (Diamond & Blatt, 1994, Frank et al., 1994; Levine et al., 1991). Specifically, adding to Benoit's work regarding the representations of mothers of FTT children the finding of a remarkable absence of aggressive/imbalanced perceptions and a resulting narrow range of representations as well as the albeit weak associations of these internal representations with specific behaviors demonstrates how attachment and psychoanalytic theory can be used together to enrich research as well as each perspective.

Second, the findings of this study show that properly administered and scored, the Rorschach can meaningfully and reliably differentiate groups of people. This study thus demonstrates that the Rorschach is a valid instrument for investigating underlying personality styles and unconscious processes; as such it offers one more piece of evidence contracting the maligning of the endeavor to find out "what is behind the system?"

More specifically, the results of this study provide further support for the Mutuality of Autonomy Scale as a reliable scale for empirically investigating differences in representational templates. On the other hand, the mixed results for the Transitional Object Scale indicate that it needs more refinement before it is deemed a valid and reliable scale.

In terms of the treatment of failure to thrive, this study can have perhaps its most meaningful implications. The significant findings regarding the uniform quality of internal representations in mothers whose children are failing to thrive as well as their insensitive and non-mutual interactions with their children concur with a growing body of research indicating the need to address psychological as well as medical issues in these dyads (Ward et al., 1993). While behavior modification might correct an entrenched, disordered feeding routine that has inadvertently rewarded the child for not eating, such treatment does not address the maternal representations that might be contributing to creating and/or sustaining this kind of interaction.

Limitations of the Study

The sample:

The nature of the sample constrains the ability to draw generalizations from the work. Although the subjects represented a variety of racial and socio-economic groups and in that sense accurately reflected the population of normal and FTT dyads, by the nature of the study they were a self-selected sample. That is, those who participated were women willing to make multiple lengthy visits to New York Hospital over several months or a year. For women whose children are diagnosed with FTT, participation might have seemed continuous with their other added medical visits as well as might have been interpreted as an opportunity to get more help for themselves and

their child. However, that there are women with FTT children who could not manage the extra burdens of participating in the study or who were from the start turned off by the idea of committing to it suggests that there are women whose children have FTT for whom the study's results might not generalize. Furthermore, being in a study as a mother who has a child with a disturbing and relatively little understood illness might have contributed to some of these women feeling scrutinized and working hard to control what they might deem as "bad," such as aggressive percepts on the Rorschach.

Also, it has to be considered that the control mothers were a group of self-selected woman as well whose motivations for being in the study—from underlying worries about their child to healthy curiosity about child development and a wish to further knowledge—could mean that these were women self-consciously monitoring themselves throughout the study. Could this mean that the data is skewed towards "health" in that the control sample, with a dose of self-monitoring, came off better than an "average" mother and child might have? While the Rorschach, as a projective test, is understood as veiling from the subject hints about "the right answers," it is possible that this kind of self-consciousness contributed to inhibition on the test.

Finally, the relatively small sample size of 52 dyads indicates that caution is needed in evaluating the results, both in terms of specific statistics, such as in the case of correlations, and in terms of the necessity of replication.

Measures:

As described previously, there is a conceptual weakness in the TOS scale as it does not measure movement from subjective to objective perspectives between and within percepts.

In addition, this study refers to mothers' inability to represent *and/or* access imbalanced internal object representations without differentiating be-

tween the two. While non-access to such representations suggests defensive processes at work, a difficulty in the ability to represent such interactions perhaps indicates deficits in symbolization around affective experience (McDougall, 1989). This study's measures do not provide information to answer which process goes on in mothers of FTT children.

Design:

A weakness in this study's design was that the author both administered and coded many of the Rorschachs. While the Rorschachs were administered approximately three years before the coding took place and the author was completely blind to the mothers' group membership regarding having an FTT or control child, her dual role undermines the results of the study. Future research would benefit from separating the roles of administering and coding Rorschachs.

Questions for Future Research

The findings of this study correlating uniform maternal representations with children's FTT status and weakly linking a lack of malevolent representations as well as qualitative deficits in symbolizing with mother-child behavioral interactions could be forwarded by a continued focus on the mothers' representational worlds. Specifically, further investigating how an inability to represent or access aggressive/imbanced representations might play a role in a child failing to thrive could be carried out by an addition of the Parent Development Interview (Slade & Aber, 1986) to the protocol. This instrument, which assesses mothers' representations of their child's affective experiences, their own, and the two of them together, would further illuminate how negative emotional interactions are constructed and handled by the

mother and, in turn, by the dyad. Also, reviewing with mothers the feeding and play video tapes and asking them to describe their experiences and interpretations of the interactions and comparing these to a "neutral observers" independently provided commentary would allow for opportunities to explore moments of maternal projection on to their infant or "aberrant interpretations" (Benoit et al., 1989) of their infant and further uncover the potential role of mothers' internal representations in maladaptive interactions and in the development of failure to thrive.

Conclusion

In a recent article entitled *The Social Construction of the Human Brain*, Eisenberg (1995) laments the irony that just as science is equilibrating itself between swings of reductionistic biology and an overzealous psychoanalytic emphasis on the environment we are in the era of managed care: we now know, Eisenberg wrote, how profoundly the environment and brain work together to create the people we are but financial concerns are limiting research to further this knowledge as well as the ability of clinicians and doctors to treat their patients with this more reasoned—and informed—approach. In contrast, *Contemporary Pediatrics* may proclaim as "myth No. 1" the hypothesis that FTT is an emotional disorder" (Frank et al., 1993) and be accurate to the extent that they are calling for a model of FTT that does not deny the child's physiological and physical contributions. But to the extent that this article serves to dismiss emotional factors in FTT it is participating in the age-old debate, nature versus nurture, medical doctor versus psychologist, and doing a disservice to the children who are failing to thrive and to their families. Although based on a relatively small sample and in need of replication,

the results of this study, like other research, suggest that there are factors in the emotional relationship between mother and child that seem to play a part in the child's failing to thrive. Compared to mothers of control children, mothers of FTT children have a constricted range of self-other representations which largely omits negatively-charged interactions, a finding which suggests they may not be able to respond to the extremes of their child's experiences and may, in being cut off to aspects of their own affective life, express these inner representations through enactments with their children. This study also showed, as has other research, that the behavioral interactions of FTT dyads versus controls are marked by maladaptive patterns, recognizable for their insensitive, conflict-ridden, and non-mutual qualities. Even if these behavior patterns are secondary to the child's FTT status rather than a primary causative factor, they represent problems in the "emotional climate" of the dyad and must be treated.

We are all products not only of our inherited biology and genes and our environments, but of the cultures and subcultures to which we belong. Within these cultures and subcultures, meanings are generated and constructed. This process of social construction serves us well, giving us a sense of community and definition; its effects are detrimental when it limits our ability to accept and synthesize other perspectives. In the case of FTT, the myopia of subgroups most powerfully affects the children.

Appendix A
Copy of Recruitment Letter

RECVY 11/103
 525 EAST 68TH STREET NEW YORK, NY 10022

THE NEW YORK HOSPITAL-CORNELL MEDICAL CENTER

DEPARTMENT OF PEDIATRICS
 SECTION OF BEHAVIORAL PEDIATRICS
 CHILD DEVELOPMENT

May 26, 1992

Dear colleague,

We are pleased to inform you that the National Institute of Child Health and Human Development has awarded a grant to study growth deficits in very young children to Dr. Mary J. Ward from the Division of Child Development, Department of Pediatrics.

Specifically, we plan to investigate the social, psychological, and physiological correlates of failure-to-thrive. We would appreciate referrals of any of your patients, aged eight to twenty-four months, with weight for age and gender below the fifth percentile on NCHS charts or with deceleration in weight gain sufficient to cross two percentile markers in less than six months.

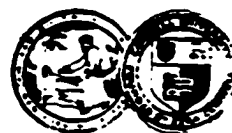
Each child will need to make three visits to The New York Hospital to receive a comprehensive intake evaluation, including medical, laboratory, nutritional, psychological, behavioral, and social evaluations. The results of this intake evaluation will be used to determine the need for specialized laboratory evaluations and subspecialty referrals. After a treatment plan is formulated, children will be followed for a year to assess progress.

Families will be directly or indirectly (through medical insurance or Medicaid) responsible for all laboratory costs and subspecialists' fees. They are not responsible for costs of procedures that are primarily of a research nature and will not be billed for project physicians' evaluations, or any of the behavioral assessments. Special circumstances will be handled individually.

For parents' time and travel expenses, they will be offered \$100 at the completion of the intake evaluation. For behavioral observations made at six and twelve months after intake, parents will be offered \$25 each time.

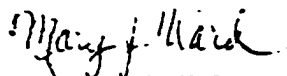
It is our goal to maintain close communication with the referring physician in every case. You will receive a summary of all findings and recommendations, given parental consent and will be asked to assist in implementing treatment plans, if you wish.

We have enclosed an outline of the procedures planned for this project for

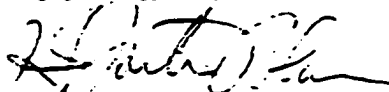


your information. For further information or to refer patients to this protocol, please call (212) 746-3583 and speak to the project coordinator, Robin Solomon. Thank you for considering our project for your patients.

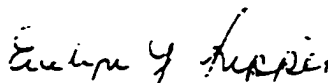
Very truly yours,



Mary J. Ward, Ph.D.
Assistant professor of
psychology in pediatrics



E. Jonathan Polan, M.D.
Associate professor of
clinical psychiatry



Evelyn G. Lipper, M.D.
Associate professor of
clinical pediatrics
Director, Division of Child Development

Appendix B

Internal Review Board Approval and Consent Forms

ROOM N-1103
625 EAST 68th STREET, NEW YORK, N.Y. 10021

THE NEW YORK HOSPITAL-CORNELL MEDICAL CENTER

DEPARTMENT OF PEDIATRICS
SECTION OF BEHAVIORAL PEDIATRICS/
CHILD DEVELOPMENT

July 31, 1992

Dr. Philip S. Barie
Chairman, Committee on Human Rights Research

Re: Protocol #1290-140CRC

Dear Dr. Barie,

I want to inform you of an addition we would like to make to our human subjects protocol. We would like to add an administration of the Rorschach ink blots.

Specifically, mothers will be asked to look at ten ink blots and to answer the question "What could this be?". After they have given percepts to all ten, they then will be asked "what made it look like that?". This procedure will be followed with all mothers on the second visit.

Clinical experience indicates this is not an emotionally upsetting exercise for most people. Indeed, because ink blots are without common meaning, most people find it non-threatening and even interesting to give their impressions of these cards. Any questions that mothers may have about this procedure will be answered patiently. They will be told they can discontinue the exercise at any time.

Attached you will find amended consent forms reflecting this addition.

Please contact me if I may provide further information.

Very truly yours,

Mary J. Ward
Mary J. Ward
Assistant professor of
psychology in pediatrics



(212) 746-6026
525 EAST 68th STREET NEW YORK N.Y. 10021

THE NEW YORK HOSPITAL-CORNELL MEDICAL CENTER

COMMITTEE ON HUMAN RIGHTS IN RESEARCH

August 19, 1992

Mary J. Ward, PhD
N-1008

Re: Protocol #1290-140CRC

Dear Dr. Ward,

The Committee on Human Rights in Research met on August 17, 1992 and approved your revision request to the above protocol entitled, "The Psychobiology of Stress in Failure-to-Thrive."

The Committee is in receipt of the revised consent form.

Sincerely,



Philip S. Barie, M.D.
Acting Vice-Chairman



DATE (MM-YY-YY)	LOCATION	VERSION

THE NEW YORK HOSPITAL-CORNELL MEDICAL CENTER
 Consent Form for Clinical Investigation



Project Title: Growth, emotions, behavior, and physiology

Subject: _____ Research Project No. _____

You are invited to participate in a study of growth, behavior, emotions, and physiological functioning. Physicians and psychologists at The New York Hospital and Cornell University Medical College are interested in studying associations among behavior, emotions, and physiological signals in parents and children. You have been invited to participate because you have a normally-growing child between 9 and 24 months of age.

For this project, you and your child will be asked not to eat or drink anything except water for two hours before your appointment. You will be asked to take in no caffeine for four hours before your appointment.

You will be asked to provide some saliva in a small tube five times and will be allowed privacy to do so. We will obtain the saliva samples from your child by putting in his/her mouth the end of a cotton dental roll with lemon Kool-Aid (TM) powder on it. We will replace the powder on the roll and encourage the child to suck or chew on the roll until it is saturated with enough saliva for our tests.

Next we'll bring you and your child to a playroom, where you can play with him/her using the toys we provide, as you please. We'll videotape your playing for 10 minutes. We understand that this is an artificial situation for you, but we'll ask you to relax as much as you can and tell us if we can do anything to make you more comfortable. At the end of 10 minutes, we'll answer your questions and will ask you some questions about your child's eating and sleeping today and about his/her typical behavior at home.

Twenty minutes after the end of the play session, we'll ask for saliva samples again from you and your child, as described above. We also will ask to videotape you and your child while the two of you have lunch. At three intervals after lunch, we will ask for saliva samples again. Finally, we'll ask you a variety of questions about your thoughts, emotions, and behavior; about experiences you and your family may have had in the past year; about people who help you; about your relationship with your spouse; and for background information about your family. We also will ask to weigh and measure you and your child.

Approximately one month from now, we will ask you to come back for another videotaping session. At this session, we will observe you child with you and another person in a variety of social situations (e.g., meeting an unfamiliar woman, experiencing two brief separations from you). We will not allow your child to become unduly distressed and you can tell us at any time that you wish to return to him/her if you want.

We will not force your child to provide saliva. Instead, we will try to distract him/her. You might feel uncomfortable about providing saliva or being videotaped. In addition, you may feel that some of our questions are personal or sensitive. You do not have to answer any questions or do anything you do not want and you may decide to discontinue participation at any time.

For your time, we will offer to pay you \$75, and do not promise any other benefits for you or your child.

Also, we will ask you to look at some images on cards and to tell us your impressions of them.

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THE NEW YORK HOSPITAL

(Use other side if necessary)

1290-140

All information obtained from you is strictly confidential and will not be revealed without your permission. In fact, no information ever is identified with your name. When a family chooses to participate in this study, a number is assigned to the family and that number is all we use to identify videotapes and all other information. All information is kept in a file locked in our office. Videotapes will be used only for the purposes of our study and will remain the property of the investigators. Any other use of information will require specific consent from you.

Whether or not you choose to participate will have no influence on your child's care or on your relations with The New York Hospital-Cornell Medical Center now or in the future.

In accordance with Federal regulations, we are obliged to inform you of the Medical Center's policy in the event physical injury occurs. If, as a result of your participation, you or your child experience physical injury from known or unknown risks of the research procedures as described, immediate medical care and treatment, including hospitalization if necessary, will be available. No monetary compensation, however, is available and you will be responsible for the costs of such medical treatment, either directly or through your medical insurance and/or other forms of medical coverage. If you have any questions about your rights as a research subject or concerning a research-related injury, please call (212)746-6026.

If you have questions, please ask us now. If you have questions later, Dr. Kessler (212-746-3298), Dr. Ward (212-746-3582), or Dr. Polan (212-746-3682) will be happy to answer them.

You are making a decision as to whether or not to participate. Your signature indicates that you have read the information provided above and have decided to do so. You may withdraw at any time without prejudice after signing this form, should you choose to discontinue participation. You will be offered a copy of this form to keep.

Signature

Date

Signature of Investigator

Signature of Witness

THE NEW YORK HOSPITAL-CORNELL MEDICAL CENTER
Consent Form for Clinical Investigation

Project Title: Growth, emotions, behavior, and physiology

Subject: Research Project No.

You are invited to participate in a study of growth, behavior, emotions, and physiological functioning. Physicians and psychologists at The New York Hospital and Cornell University Medical College are interested in studying associations among behavior, emotions, and physiological signals in parents and children. You have been invited to participate because you have a child between 9 and 24 months of age whose weight is below standards for age.

For this project, you and your child will be asked not to eat or drink anything except water for two hours before your appointment. You will be asked to take in no caffeine for four hours before your appointment.

You will be asked to provide some saliva in a small tube five times and will be allowed privacy to do so. We will obtain the saliva samples from your child by putting in his/her mouth the end of a cotton dental roll with unsweetened lemon Kool-Aid (TM) powder on it. We will replace the powder on the roll and encourage the child to suck or chew on the roll until it is saturated with enough saliva for our tests.

Next we'll bring you and your child to a playroom, where you can play with him/her using the toys we provide, as you please. We'll videotape your playing for 10 minutes. We understand that this is an artificial situation for you, but we'll ask you to relax as much as you can and tell us if we can do anything to make you more comfortable. At the end of 10 minutes, we'll answer your questions and will ask you some questions about your child's eating and sleeping today and about his/her typical behavior at home.

Twenty minutes after the end of the play session, we'll ask for saliva samples again from you and your child, as described above. We also will ask to videotape you and your child while the two of you have lunch. At three intervals after lunch, we will ask for saliva samples again. Finally, we'll ask you a variety of questions about your thoughts, emotions, and behavior; about experiences you and your family may have had in the past year; about people who help you; about your relationship with your spouse; and for background information about your family. We also will ask to weigh and measure you and your child.

Approximately one month from now, we will ask you to come back for another videotaping session. At this session, we will observe you child with you and another person in a variety of social situations (e.g., meeting an unfamiliar woman and experiencing two brief separations from you). We will not allow your child to become unduly distressed and you can tell us at any time that you wish to return to him/her if you want. Also, we will ask you to look at some images on cards and to tell us your impressions of them.

We will not force your child to provide saliva. Instead, we will try to distract him/her. You might feel uncomfortable about providing saliva or being videotaped. In addition, you may feel that some of our questions are personal or sensitive. You do not have to answer any questions or do anything you do not want and you may decide to discontinue participation at any time.

THE NEW YORK HOSPITAL

(Use other side if necessary.)

Your child also will receive a comprehensive medical, nutritional, and psychosocial evaluation of his/her growth. All evaluations are begun on an outpatient basis, although individual circumstances may require consideration of an admission. Parents will participate in the decision about admission. The precise nature of your child's medical evaluation will be determined in large measure by a detailed medical history and physical assessment.

Studies to be performed on all children include screening tests of blood, urine, and stool; bone age; and nutritional, developmental, and psychosocial assessments. Assessments of physiological indices of growth, such as growth hormone, stool fat, and serum zinc will be performed when admission is being considered. All additional laboratory procedures and/or subspecialty evaluations will be determined strictly by individual need. None of these evaluations is "experimental," and all medical procedures will be performed by trained medical personnel with the usual precautions. If your child is hospitalized, you will be invited and encouraged to participate actively in his/her care and feeding.

For your time, we will offer to pay you \$100, and do not promise any other benefits for you or your child.

All information obtained in this study, other than clinical information related directly to your child's medical assessment, will remain strictly confidential and will not be revealed without your permission. In fact, no information ever is identified with your name. When a family chooses to participate in this study, a number is assigned to the family and that number is all we use to identify videotapes and all other information. All information is kept in a file locked in our office. Videotapes will be used only for research purposes and will remain the property of the investigators. Any other use (e.g., educational) will require your specific consent.

Parents are directly or indirectly (through medical insurance) responsible for all medical and hospitalization costs for the child's evaluation. They are not responsible for costs of procedures that are primarily of a research nature (i.e., videotaping, and laboratory procedures that do not pertain directly to the clinical evaluation). Special circumstances will be handled individually. Whether or not you choose to participate will have no influence on your child's care or on your relations with The New York Hospital-Cornell Medical Center now or in the future.

In accordance with Federal regulations, we are obliged to inform you of the Medical Center's policy in the event physical injury occurs. If, as a result of your participation, you or your child experience physical injury from known or unknown risks of the research procedures as described, immediate medical care and treatment, including hospitalization if necessary, will be available. No monetary compensation, however, is available and you will be responsible for the costs of such medical treatment, either directly or through your medical insurance and/or other forms of medical coverage. If you have any questions about your rights as a research subject or about a research-related injury, please

call 212-746-6020.

If you have questions, please ask us now. If you have questions later, Dr. Lipper (212-746-3538), Dr. Ward (212-746-3582), or Dr. Polan (212-746-3682) will be happy to answer them.

You are making a decision as to whether or not to participate. Your signature indicates that you have read the information provided above and have decided to do so. You may withdraw at any time without prejudice after signing this form, should you choose to discontinue participation. You will be offered a copy of this form to keep.

Signature

Date

Signature of Investigator

Signature of Witness

Appendix C

Mutuality of Autonomy Scale (MOAS)

7	A figure is dominated by catastrophically malevolent, engulfing forces	
6	Physical destruction of one figure by another, decidedly imbalanced, destructive	Scores 5, 6, 7, reflect increasing dominance and destruction of one figure over another
5	Relationships characterized by control or dominance of one figure over another	
4	One figure merely the reflection or imprint of another	Need for another to give sense of cohesion; narcissistic issues pivotal
3	Two figures lacking balance, leaning on one another, or needing external support	
2	Parallel activity	Most adaptive; autonomy of self is maintained in interactions
1	Mutual interaction	

Appendix D

TOS Manual Ammended

List of categories:

A. Subject treats percept as if it's a real object.

B. Treating colors as concrete objects; may include black or white.

C. The card or percept becomes incorporated into the subject's experience and/or percept is primarily justified by personal experience and not by real qualities of the blot. (Formerly C and C1).

C18. Inability to list determinants that facilitate seeing percept so refer to parts of percept as if real to explain what see. (Use of 'looks like', 'reminds me of', 'as if', markers against counting in this category.)

C2. Subject makes reference to action required to form the percept. Connotation is of forming percept as if it exists. Fact that this is process with a card lost.

C3. Subject indicates feeling has in response to card, or negates such a feeling. Must be pretty direct, conscious expression of feeling.

C4. Subject owns the percept. Use of personal pronoun.

D. Reference to cards themselves or to the actual act of creating the cards. Reality oriented to cards, very strongly concrete. Can impede process of "seeing" anything, giving percepts. Most often will not be seen with As, Cs, C18, C2s, C3s etc. Smart-alec, intellectual sense of know what cards really are, can't pull one over on me. Resistance to play and come up with percepts. In the know with the experimenter.

D1. Reference to the changing nature of cards and/or percepts seen. Percept alive, real to viewer, not concretely oriented to reality of card. The opposite.

D2. Wanting to do something to the card—something is wrong with the card and an attempt is made to make the percept more accurate as a representation. (Unlike previously discussed, is not necessarily oriented to reality, just wants card changed to fit *their* reality, their fantasy, their percept.)

D3. New category: attempt to contain tendency of losing distance, having percepts become real, by seeing something close to what card truly is. Most often goes with A.

Discussion and examples:

A. Subject treats percept as if it's a real object. Would often get scored with a movement response, even a tendency to movement, even though we aren't marking those.

Examples:

1. It's a cat sliced in half... Somebody killed the cat.
(explanation, is really a cat for something to have happened to, justifying why it looks as it does)
2. A hippo—he's facing you—I have the thought he's going to kill you, to stomp all over your face.
(explanation, is a hippo that exists to do damage)

3. It looks like a spider's web. These are spiders, these two, and these are insects caught in spider's web. Can't see web; these are insects caught inside. (WMLL?) Well, it looks like it has lots of arms and legs, or just legs, Idk, I'm not sure they're considered arms. (WMLL insects caught?) Well, Idk, often have multiple legs, something I don't like at all, creepy crawly types. ... Insects have antennas. (You said caught in web, caught in web as if?) Well, the spider at web, they were non-challantely going about their business and they got caught in the web. That's pretty much how it happens usually everyday. Spider gets ... I don't know, I've never really seen it happen. I just imagine that's how it happens.

(explanation, is something happening, insects there caught in invisible spider's web)

Also score for this: C, C1g

4. Leaf, all of it is the leaf, but this is where the leaf is dried up so it's like broken off. (WMLL?) Just the shape.
(explanation, leaf exists to have had a history to be broken off)

NOT C18 because can say "the shape."

5. Mink wrap with broad collar. (Where's that?) This here is the collar, the broad collar, this here is the front of the wrap, of the mink wrap, this here is the tail that is, like it is just put over, you don't have to slip your hands, here is over, right between here is where your arms would go, so there's no zippers, just thrown on you. The long tail makes it ll the mink and the collar makes it ll the wrap.

(description of a coat that really exists to be put on)

Also score for this C1g

6. Blood on card. (WMLL?) the way the blood is splattered.
(explanation, blood is real. Gets a C18)

7. Blood on card. (WMLL?) the way the red dots are.
(doesn't get a C18)

MARGINALLY A: Costume. Looks like a costume, here, this is the stand that it is on. This long line here is the zipper, and this is just pieces of material that's just in different lengths that's sewed on. This is the arms to the costume. The way it's shaped makes it look like the costume.

(explanation, just elaborating on what they saw; able to see line of card as a zipper and say that; but "different lengths been sewn on" makes it seem as if it has a history and exists)

Not A: That's a butterfly. Now that's a butterfly. That's a butterfly. Now that's a butterfly. He's a butterfly. (Where?) That's a butterfly. (You said all of him?) The whole thing is a butterfly. He's a butterfly. (WMLL?) I don't know, it's a butterfly.

(explanation, just naming, no sense is enlivened, plus, such an ordinary response, ordinariness can be a marker against A; just not a sense alive and unique with a history or event going on)

NOT A: A butterfly. I see a butterfly again. Same as is the other one. (Show me, is that the bottom?) That's the bottom and that's the top and those are the two little things. (WMLL?) I don't know. (WMLL?) Those two wings.

(I see again a butterfly, not sense it is a real, alive butterfly for subject) **Do score here: C18**

NOT A: Some kind of moth or something. Straight up here, with the hump and then the wings. (Whole?) Yes. (WMLL?) the wings, and the slim body in the middle.

Do score here: C18

NOT A: It's a bat.

(explanation, just a figure of speech, not as shocking as calling it blood, is ordinary, not elaborated.)

NOT A: Yeah, a leaf, um yeah, it could be a leaf if this could be highlights in the leaf right here. Or it could be a leaf that is partially shredded. (WMLL?) Well, um, it really doesn't ll a leaf but I've seen some really kind of, in the fall and autumn, the leafs kind of ruffled on the ground and kind of torn apart and kind of raggedy, you know, that could be a leaf.

(explanation, personal associations, no sense percept has become real; "could be" goes against realness and "A"ness;)

Do score C

NOT A: The green part looks like these two funny heads. They're not human but cartoon looking. They have big round noses and pursed lips, the lips do something funny, they have what would look like a chin, but more like a wart coming of the face. Also pointing ears and big round eyes. (WMLL?) The shape, the dark part. It's a green face.

(explanation, whole feel not as if real, last line may seem to suggest thinks real, but too weak, describing what seeing)

NOT A: Abstract piece of art. Yeah, ah uh, cause abstract piece of art is something is hard to interpret to me. You really don't see much of anything. It's open to interpretation. Anyone can come along say oh it's this type of thing or another thing; and then the artists or some type of person who has some other thought or some notion of what it might be or maybe he feels bad about other people picking on his work. (WMLL?) the colors and the different kind of design.

(explanation, more sense of C then something in percept has become real to subject. **Also score new category D3**)

B: Treating colors as concrete objects; may include black or white.

Examples:

1. I see this green as warmth, tranquillity, a secure haven.
2. All this pink is good and beautiful and happy.
3. Yellow, hope, Yellow means hope to me.

C. The card or percept becomes incorporated into the subject's experience and/or percept is *primarily* justified by personal experience and not by real qualities of the blot. (Formerly C and C1.)

Examples:

1. Just clouds or something. Just looking for formations and sometimes I do the same with clouds.

(What "I" do in real life is same as what "I" do with percepts on card, incorporated into subject's real experience.)

2. It looks like a spider's web. These are spiders, these two, and these are insects caught in spider's web. Can't see web; these are insects caught inside. (WMLL?) Well, it looks like it has lots of arms and legs, or just legs, Idk, I'm not sure they're considered arms. (WMLL insects caught?) Well, Idk, often have multiple legs, **something I don't like at all, creepy crawly types**. ... Insects have antennas. (You said caught in web, caught in web as if?) Well, the spider at web, they were non-challantely going about their business and they got caught in the web. **That's pretty much how it happens usually everyday.** Spider gets ... **I don't know, I've never really seen it happen. I just imagine that's how it happens.**

(explanation, subject shows both personal associations to blot and sense of bringing percepts into life experience)

Also gets an A and a C1g

3. It ll a bearskin rug. I have a sheepskin rug at home that looks just like it.

(explanation, personal association)

4. It could be a snowflake. Yeah, a snow... o.k., I was reading once about snowflakes and about how the crystals form, you just feel, they're kind of like a glump, but if you really were to like scrape them or put them in your hand you could see they had all kind of little shapes, they're no two snowflakes alike. (Where is snowflake?) I mean the whole entire thing would be a snowflake but of course it would be white. (WMLL?) Well, it doesn't really ll a snowflake, unless I mean if you put a snowflake under a microscope and then it could be a snowflake. Sometimes things can be things that they don't appear to be.

(explanation, personal associations; putting it under a microscope implies it's brought into patient's experience)

5. Yeah, a leaf, um yeah, it could be a leaf if this could be highlights in the leaf right here. Or it could be a leaf that is partially shredded. (WMLL?) Well, um, it really doesn't ll a leaf but I've seen some really kind of, in the fall and autumn, the leafs kind of ruffled on the ground and kind of torn apart and kind of raggedy, you know, that could be a leaf.

(explanation, personal experience associated to, but also brought into her experience;)

6. These are two soccer players from Iran and they both have a ball which they are going to play with. (WMLL?) Just the fact that they were playing soccer, Iranians play a lot of soccer and I love Iranians.

C18: Inability to list determinants that facilitate seeing percept so refer to parts of percept as if real to explain what see. (Use of looks like, reminds me of, as if, markers *against* counting as this category.)

Examples:

1. (WMLL two people standing over a melting pot?) The way they are standing.

(explanation, to justify percept refers to percept as if real, not to parts of cards such as shape of drawing, red coloring under shape that ll a pot.)

2. Some kind of moth or something. Straight up here, with the hump and then the wings. (Whole?) Yes. (WMLL?) the wings, and the slim body in the middle.

(explanation, list qualities the make it ll a moth as if moth exists, names part of moth as if moth exists, not qualities of card.)

Note: does not get scored A.

3. An angel. The humps up the hands are up like they're praying and the wings on the side like they're really large big wings. And the legs. WMLL? The praying hands.

4. Yeah, a leaf, um yeah, it could be a leaf if this could be highlights in the leaf right here. Or it could be a leaf that is partially shredded. (WMLL?) Well, um, it really doesn't ll a leaf but I've seen some really kind of, in the fall and autumn, the leafs kind of ruffled on the ground and kind of torn apart and kind of raggedy, you know, that could be a leaf.

(explanation, see highlights in the leaf, having it be partially shredded, as if it exists, rather than refer to parts of blot that make it look like highlights or as if shredded.)

NOT C18: That's a butterfly. Now that's a butterfly. That's a butterfly. Now that's a butterfly. He's a butterfly. (Where?) That's a butterfly. (You said all of him?) The whole thing is a butterfly. He's a butterfly. (WMLL?) I don't know, it's a butterfly.

(explanation, just can't list determinants but not falling back on referring to percept as if real to describe it)

NOT C1g: It could be a snowflake. Yeah, a snow... o.k., I was reading once about snowflakes and about how the crystals form, you just feel, they're kind of like a glump, but if you really were to like scrape them or put them in your hand you could see they had all kind of little shapes, they're no two snowflakes alike. (Where is snowflake?) I mean the whole entire thing would be a snowflake but of course it would be white. (WMLL?) Well, it doesn't really ll a snowflake, unless I mean if you put a snowflake under a microscope and then it could be a snowflake. Sometimes things can be things that they don't appear to be.

(no reference to snowflake, none to how it looks as a real snowflake; even when says 'when you put it under microscope, nothing about how it looks.)

C2. Subject makes reference to action required to form the percept. Connotation is of forming percept as if it exists. Fact that this is a process with a card is lost.

Examples:

1. I'm trying to look for life, a human being or something. From looking high down to the ground, maybe it would be something like that.

2. Oh, what could it be? O.k., if you really use your imagination, it's like from, if you're down, say you're a small child and you were looking up, it's like that sort of perspective, it could be a giant, you can see the feet right here, or a monster or something. (Subject goes onto elaborate more about percept.)

(in mind, within experience of make percept, do what it in takes in mind)

NOT C2: It ll a cloud pattern or formation. (WMLL?) Cause if you just keep turning it ll these shapeless figures that just get softer at the edges. Also the coloration on this is such that it has a 3-d quality.

(explanation, because outside of percept, with a card, and suggesting actually doing something to card and therefore not from within experience of what seeing, able to do what need to do to form percept in mind, as part of play/fantasy)

C3. Subject indicates feeling has in response to card, or negates such a feeling. (Must be pretty direct, conscious expression of feeling.)

Examples:

1. When I saw the eyes it got really scary.

2. If I wanted to tell you this could conceivably titillate me by suggesting the possibility of a phallus at the bottom, but it doesn't really suggest that.

3. I enjoyed the colors down here.

4. Or a moth. I hate moths. In fact, moths remind me of miniature bats. I'm afraid I'm phobic about insects. ... Yeah, now the moth Idk cause I've never seen one with ears, I guess they have ears. Idk. It's the only other thing. You know, moths remind me of miniature bats. Cause also the color. I know there are moths that are (goes on to talk about color qualities of moths... .)

NOT C3: These are grotesque, esthetically ugly.
(explanation, ugly is not a feeling.)

NOT C3: Fish with an open mouth, kind of distorted but the whole damn thing is distorted.
(explanation, distorted is not a feeling.)

NOT C3: I don't know, I really don't know that this could be. Something ugly, really, I just don't know what it is at all. That's a stretch, I don't see anything.
(explanation, ugly is not a feeling, implies one but isn't one.)

C4. Subject owns the percept—use of personal pronoun.

Examples:

1. These are my two cats here.
2. The back of my dog's head and body.
3. This is my butterfly.

D. Reference to cards themselves or to the actual act of creating the cards. Reality oriented to cards, very strongly concrete. Can impede process of "seeing" anything, giving percepts. Most often will not be seen with As, Cs, C1s, C2s, C3s etc. Smart-alec, intellectual sense of know what cards really are, can't pull one over on me. Resistance to play and come up with percepts. In the know with the experimenter.

Examples:

1. A butterfly, or someone taking a paper and folding it, now spreading it out.
(explanation, going to actual creation of cards gets a lot of attention.)

2. This is actually an ink blot? Or are you sure someone didn't draw that?
(explanation, interested in reality of how card was made)
3. This looks like multiple images based on color (then goes onto give filled-out percepts of what sees, so doesn't impede process of generating percepts. Initially distant and concrete, and then plays.)
4. Dye. It's runny here, it's runny here, and it's also on the black part stained. (stained as if?) Stained as if it fell there. (A.E.?) just the two tone colors, see it's darker here and lighter there.
(explanation, almost just a description of the card as is)

Marginally D: What bright red turbans they're wearing, Russians are heavy on black and red, flowing cloaks. (WMLL?) The ink, the way the ink is on the paper.

(just listing determinants really)

Marginally D: It ll a cloud pattern or formation. (WMLL?) Cause if you just keep turning it ll these shapeless figures that just get softer at the edges. Also the coloration on this is such that it has a 3-d quality.

(explanation, really just giving answer of determinants, even with 3-d idea)

NOT D: A rainbow. This is the rainbow. This is the beginning, comes all the way down, here is like a fire, the color. (WMLL?) the way it's joined in the middle. The different colors also make it ll the rainbow. How it changes colors.

(explanation, joined in the middle not enough reference to how card is made)

NOT D: A butterfly. (WMLL?) How it's made. How it is, that's a butterfly, all of them are butterflies. They all look like butterflies.

(explanation, how it's made is too vague, particularly that she then goes on to state it's a butterfly. If referred more to what means by 'how it's made' then might qualify.)

NOT D: A bat, here are it's ears, they're kind of exaggerated, and these are the wings and these are ... and this is the body. ...

(explanation, ears are exaggerated, not pulled out of seeing percept to talk of reality of card, but opposite, is describing bat.)

D1: References to the changing nature of cards and/or percepts seen. Percept alive, real to viewer. NOT CONCRETELY ORIENTED TO REALITY OF CARD. The opposite.

Examples:

1. All this pink, a path through the tunnel, all of this pink has to funnel through, it's only gone half way so far.
2. A rainbow. This is the rainbow. This is the beginning, comes all the way down, here is like a fire, the color. (WMLL?) the way it's joined in the middle. The different colors also make it ll the rainbow. How it changes colors.

D2: Wanting to do something to the card—something is wrong with the card and an attempt is made to make the percept more accurate as a representation. (Unlike previously discussed, is not necessarily oriented to reality, just wants card changed to fit *their* reality, their fantasy, their percept.)

Examples:

1. Maybe a dark cloud. If you take this away and maybe this away, you have maybe a cloud.
2. The top of a man's chest ... the whole thing right in there, just cut that out.
3. Bug. I guess this part right here. (WMLL?) Those things down here, Idk what you call them, the head. Little tiny two eyes over there and the little feet in the bottom you could see, and what else. Hmm. Little feets over here, just cut these things, well, Idk, really long legs. This part is, Idk, extra little feet here, this part you could cut out I guess.
4. Parrot. Right here, ll a little beak right here, the beak, the eyes. (WMLL?) um, geez, just cut this part off, yeah, and the tail, hmm. That's it. (A.E?) the face, the face mostly.

D3 New Category: attempt to contain tendency of losing distance, having percepts become real, by seeing something close to what card truly is. Most often goes with A.

Examples:

1. A mess! ll somebody threw just threw shit and just threw it at the board. (Threw as if?) slob. (WMLL?) LL somebody just put a piece of paper up there and started throwing stuff all over it, it's got splashes all over it.
(explanation, able to play and elaborate so doesn't seem like based on reality of card and simply stops there. Sees it as something, a mess, whole percept elaborated around that; not a know-it-all truth of card)

Would give it an A also.

(it's got splashes all over is like line having blood on it;)

2. Abstract drawing. All of it, just this thing here, they look like legs. (WMLL?) Shape and also because has no form. It's just thrown on the piece of board.

(makes it into something, just like saying it's a cow, or some other percept. not a know-it-all truth of card)

Would give it an A also.

3. Finger painting. Here, this is finger painting. The pink part and the brown parts over here. The gray is finger painting. (WMLL?) The long lines, smooth looking, that's it.

Would give it an A also.

4. Maybe, ah, watercolors. A child's in kindergarten or something. Finger painting. (WMLL?) It kind of ll something I did back in Kindergarten or something. Yeah, it's like finger painting with watercolors. (AS IF?) Oh, just something part of classroom activity. I'm also starting to think it could be with a brush also.

Also get C, A.

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