Mother–infant group psychotherapy as an intensive treatment in early interaction among mothers with substance abuse problems

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Abstract  In this article we present a novel method of outpatient care: brief, dynamic mother–infant group psychotherapy with mothers who have substance use problems. In this therapy, substance abuse treatment is part of mental health and parenting interventions. The focus is on preventing disturbance in the mother–infant relationship in this high-risk group. The clinical material is taken from 16 mother–infant dyads from six psychotherapy groups, which met weekly over six months from pregnancy to post-partum. The therapy process consists of 20–24 three-hour sessions. The basis of the therapy is to offer mothers experience of care, which they, in turn, can give to their infants. In this paper we analyse the core therapeutic elements that may contribute to better mothering and child development. They involve: the group providing a symbolic maternal lap, and the meeting of the mothers’ and the infants’ needs. It is hoped that this may offer the mothers a new experience within which to reappraise their early memories. This may help prevent them from projecting traumatic past experiences onto their infants. Our analyses show that in the therapy, mothers, feeling safe within the group, gradually experienced pleasure with their infants and their peers. These effects, according to the mothers, were the most noticeable. Brief dynamic mother–infant group psychotherapy seems to be a promising form of treatment for those substance-abusing women able to commit to outpatient care and examine the causes of their drug dependence. The groups may also be used as a diagnostic tool to detect problems in early mother-baby interaction.

Keywords  Mother; infant; substance abuse; therapeutic group.

Introduction

Women with a history of substance abuse face a dilemma when becoming mothers. Many of them want to be good mothers, but are aware of the harm that their drug abuse could cause to their child’s health and development. Typically, substance-abusing mothers have multiple stressors and risks in their lives, both past and present, which demand particular treatments and interventions. They are often single parents who lack familial social support networks (Hans et al., 1999; Pajulo et al., 1999, 2001b;
Schuler et al., 2000), and frequently suffer from mental illness such as depression and anxiety (Hans et al., 1999; Luthar and Suchman, 2000; Pajulo, 2001). Their infants may have neurobiological problems due to drug exposure in utero, resulting in premature birth and low birth weight along with slow sensorimotor development (Mayes and Truman, 2002), which makes mothering and dyadic interaction more difficult.

Pregnancy provides psychological challenges and opportunities. There is evidence that substance-dependent women are often concerned about the well-being and development of their babies and they are willing to alter their drug-centred lifestyle and accept professional help during pregnancy (Hans et al., 1999; Pajulo et al., 2001b, 2004). They need effective help in reorganising both their external and internal worlds, through stopping their drug use and starting rehabilitation. This makes it possible for them to replace their drug-related social environment with one more conducive to being the mother of a newborn.

It is important to develop treatment methods for substance-dependent mothers which can enhance both maternal mental health and early mother–child interaction, promoting healthy child development and new social relationships. Effective treatment is essential because large numbers of substance-abusing women are of childbearing age. In a Finnish sample of pregnant women, the prevalence of drug abuse was 6% (Pajulo, 2001). Research suggests that the most effective treatment models are those which integrate substance-abuse treatment with mental health and parenting interventions (Field et al., 1998; Hans et al., 1999; Moore and Finkelstein, 2001), and which are initiated in pregnancy (Camp and Finkelstein, 1997; Pajulo et al., 2001b).

Aims of the study

In this article, we describe the psychoanalytically-oriented mother–infant group therapy developed in Finland by Ritva Belt. The aim of the project is to care for substance-abusing mothers in a holistic way, and support the mother–infant relationship right from the very beginning. This therapy integrates substance abuse treatment with mental health and parenting interventions. It is vital that the therapy should start as early as possible, ideally before delivery. This focus differs from that of conventional interactive parent–infant therapy, where the starting point is developmental problems and disturbance in the mother–infant interaction (Baradon, 2003). Our choice of group work rather than individual work is based on the assumption that the peer group could function both as a support for recovery and a pressure for abstinence. Being with fellow users allows mothers to share their often painful drug-related experiences, along with their feelings of guilt and shame. This analysis of the content of the therapy and its curative factors is based on clinical material from 16 mother–infant dyads participating in six therapy groups of 20–24 three-hour sessions. The mothers would have liked more sessions, but there were financial constraints.

The group as mother

Experiencing the group as mother (Scheidlinger, 1982) can provide mothers with a safe place in which to learn to enjoy motherhood and refrain from projecting past bad
experiences onto their babies. The therapeutic experience may function as an effective support against relapse (Moore and Finkelstein, 2001). Meaningful early interaction with the child and abstinence from drugs may open a new space in the mother’s mind. The pleasure the mother derives from her infant and the sharing of experience in the peer group are thought to be healing elements. Below, we present the theoretical perspectives underlying the intervention, its content and major features, followed by clinical vignettes.

Structure and context of the group intervention

Substance-dependent women face the complex daily social problems typical of marginalised groups. In order to concentrate on their inner chaos while in therapy, they need practical help to cope with the external chaos, demands of, and conflicts in their lives. Therefore, the outpatient project ‘Find the Diamonds’ has created a regional model for the treatment of pregnant substance-abusing women that includes a systematic pathway into different treatment alternatives. Referral into our brief dynamic mother–infant group psychotherapy is one part of this regional model. Working pairs of social worker/midwife and psychiatric nurse/psychiatrist recruit substance-abusing pregnant women or mothers at the regional prenatal clinics as potential participants. They are then referred to therapists for assessment; during assessment they are interviewed three to four times including, routinely, one home visit (James, 2004). The most important criterion for treatment is the mother’s motivation to recover and adhere to treatment.

The women are then provided with a treatment network that consists of professionals and those close to the mother. The network involves a social worker from the Child Protection Agency, professional representatives from a psychiatric clinic for drug abusers, a public health nurse and a local family worker. The treatment network includes the mother’s nuclear family and the people closest to her. It is important that the psychotherapy is an integral part of the mother’s life; therefore, one of the therapists in the mother–infant group is an active member of the treatment network. Ideally, the therapist will make contact with the mother’s partner or the father of the child. The treatment contract is negotiated and signed at the network meeting; it includes drug screening (urine analyses) and an explanation of the consequences of positive test results.

Outside the sessions, one of the two therapists is available by phone. This is essential for maintaining the strong holding position we are building. A follow-up meeting is arranged to take place four to six months after the group sessions are over. It is recommended that the mother begins the group therapy during the last trimester of pregnancy, or at the latest when the baby is two to three months old, because of the importance of the perinatal period for attachment. The group size remains small, preferably three or four mother–infant dyads, because of the need for intensive attention.

The group room

The group therapy room is designed to be a comfortable, home-like, child-friendly environment. It has a large table in the middle, surrounded by chairs and baby seats,
cradles, mirrors, mattresses and pillows. There are toys. In short, there are all the necessities for a mother and baby. Videos, a CD player and a video camera are available for supporting mother–child interaction. Next to the room there is a lavatory, a kitchen and a cupboard for therapy material.

The therapy

The therapy follows a loose structure. The first session involves instructions and agreement around rules and confidentiality. Therapy sessions start with coffee and home-made bread and there is a break for lunch. Apart from the initial instructions, we provide no further guidance.

In our therapy model there is a group therapist and a co-therapist, both women, to provide a model of two adults working together. The therapists share some communal tasks such as serving food and encouraging mother–baby interaction. They also have separate tasks. The group psychotherapist, who is a child psychiatrist, focuses on the group dynamics and the mothers’ insight into possible reasons behind their feelings, thinking and behaviour, including their use of substances. The co-therapist, who is a nurse, has responsibility for practical issues, including the therapy arrangements and liaising with the network. Group members can have individual or marital counselling, as well as phone contact with the therapists, between sessions.

Analysis

The analysis of our brief dynamic mother–infant group therapy presented here is based on 16 mother–child dyads; the mothers were between the ages of 18 and 28 years. What all our participants had in common was that they became mothers in highly conflictual, difficult circumstances. Most mothers (10 out of 16) began abusing drugs early on, before the age of 15. They had used various substances, but mostly amphetamines. Four of the mothers had been opioid-dependent and one had been in buprenorfin substitute care. Before or during the group process most of the mothers had begun antidepressant or other medication prescribed by a psychiatrist. If a baby had to stay in detoxification after birth, the mother would still participate in the group. It was hoped that the group would help her to keep her baby in mind (Slade, 2002).

Maternal substance abuse, mental health and parenting

Substance abuse can be understood as an attempt to cope with painful experiences and feelings, and defend one’s integrity by escaping conflicts and relying on excessive pleasure. It is possible that substance dependence developed as the result of a failure to solve a mental health problem. There is evidence that psychiatric disorders are common among substance-abusing mothers, and that these disorders often precede the abuse (Hans et al., 1999). Depression and anxiety disorders (Hans et al., 1999; Luthar and Suchman, 2000; Pajulo, 2001) and post-traumatic stress disorders (Luthar and Suchman, 2000) are commonly diagnosed along with substance abuse. According to a Finnish study (Pajulo et al., 2001a), 40% of pregnant substance-abusing women in
residential care had depression, diagnosed at six months postpartum. Hans et al. (1999) showed that among opioid-dependent pregnant women, 34% met lifetime diagnosis criteria for depression and 53% for personality disorder.

Furthermore, research shows that many substance-abusing women have had childhood experience of inadequate parental care or maltreatment (Luthar and Suchman, 2000; Savonlahti et al., 2004), and insecure parent–child attachment (Fonagy et al., 1997). Childhood sexual abuse is also a common feature, although estimates of its prevalence vary, ranging between 12% and 85% (Beckman, 1994). There is evidence of family problems in childhood such as transgenerational substance dependence, parental conflict and divorce (Camp and Finkelstein, 1997). A history of neglect and abuse in substance-abusing mothers often results in negative representations of motherhood and parenting (Pajulo, 2001).

Substance abuse undermines the protective maternal role and may cause problems in the mother–infant relationship. Research shows that substance-abusing mothers, compared to non-drug-abusing mothers, have a tendency to talk less to their infants and enjoy them less, and be either more passive or more intrusive in their interactions with the baby (Mayes and Truman, 2002; Pajulo et al., 2001b). Furthermore, opioid-dependent women have been found to be less responsive and harsher with their infants than non-drug-abusing mothers (Hans et al., 1999). Substance-abusing mothers display a low tolerance of frustration and poor self-esteem, on the one hand, but high expectations of motherhood on the other (Pajulo et al., 2000). Researchers agree that comorbid maternal psychopathology may have a more significant influence on the quality of parenting behaviour than drug use alone. Antisocial and personality disorders and depression constitute especially serious risks for negative parenting and a dysfunctional mother–child relationship (Hans et al., 1999).

Distortions in mother–child interaction, lack of nurturing experiences and insecure attachment pose serious risks for the infant’s well-being and development (Jacobson and Jacobson, 2001). Frustration experienced by the mother in her interaction with her baby often precedes relapse, and is a predictor of neglect and abuse of the child (Black and Mayer, 1980). Rewarding and positive experiences with the infant may help break the vicious circle of traumatic childhood experiences, violent and abusive relationships and helplessness. The therapy provides mothers with a chance to acknowledge their own childhood experiences. By focusing on their concerns as parents, and recognising interpersonal and psychological needs, their ability to control their own behaviour and drug abuse may be improved. Frustration and helplessness can be replaced with joy and pleasure in their baby. It is important that substance-abusing mothers are seen as having the potential to be capable parents, and not only as possibly relapsing addicts (Hans et al., 1999; Luthar and Suchman, 2000).

The characteristics and effectiveness of mother–infant group therapy

Mother–infant groups for drug-dependent mothers are psychoanalytically-oriented and time-limited. In Molnos’s (1995) terminology they are ‘brief dynamic psychotherapy’ groups, which have a clearly defined aim. No research is available on brief psychoanalytically-oriented group therapies for substance-abusing mothers and their
However, there have been analyses of the therapeutic effects of mother–infant group therapies in general (James, 2004; Paul and Thomson-Salo, 1997; Reynolds 2003; Trad, 1994) and studies with other client groups, such as mothers and babies in postpartum crisis (Pedrina, 2004). Reynolds (2003) introduced ‘mindful parenting’ groups to promote parental reflective capacity and the attachment relationship between parents and infants in parent–infant group therapy for at-risk families. Paul and Thomson-Salo (1997) state that peer support makes it possible for mothers to examine their feelings of guilt and blame, and that the group provides an opportunity for greater therapeutic identification, both with their own baby and with other mothers.

Luthar and Suchman (2000) developed supportive and developmentally-informed group psychotherapy for heroin-addicted mothers with children under 16. The relational psychotherapy mothers’ group (RPMG) is based on an add-on treatment approach which complements standard methadone counselling. After the 24-week treatment period, the mothers in the intervention group showed a lower level of risk for child maltreatment and a greater involvement with their children. The retention rate in therapy was as high as 86%. RPMG researchers recommend that half the group sessions should be focused on the mothers’ own psychological needs and only after that should they concentrate on specific parenting issues (Luthar and Suchman, 2000).

In the therapeutic group described in this paper, the mothers’ attention is focused on the here-and-now and the therapists actively facilitate transference phenomena (McKenzie, 1990). Positive transference is emphasised, although it is necessary also to interpret the more obvious negative transference (Paul and Thomson-Salo, 1997).

Psychoanalytically-oriented mother–infant group therapies are challenging for the therapist and require enthusiasm and commitment (James, 2004). The nature of drug dependency increases the challenge, and involves some specific skills. The therapist needs to show confidence in the drug-abusing mothers’ capacity for improvement. The therapist encourages the mothers’ insights and respects their common and unique experiences. It is important that the therapist has the psychological capacity to contain the intense negative feelings that mothers are likely to project onto her. With substance-dependent mothers, the negative transference usually emerges when the therapist has to set boundaries, such as drug-screening practices.

The therapist needs therapeutic knowledge and experience of both adults and children because she works simultaneously with the parent and the infant. She should know about infant psychology and early child development, and have experience of interactive treatment modes along with the ability to observe and listen (Cramer, 2000). An understanding of group processes is necessary, as well as the capacity to follow numerous dynamic patterns simultaneously (Rosenberg, 1993). Up-to-date information about drugs, addiction treatment and psychological dependency are relevant. For the therapist, it is important to understand the infantile aspects of the mothers evoked in the therapy (Mitrani, 2001). The therapist has to be aware of developing possessive love or overprotectiveness towards the infants. Naturally the therapist intervenes in situations where the child is at risk of neglect.

This group shares similarities with other client groups but also involves special and unique themes. Below, we look at therapeutic and curative elements and themes in the data. These include negative projections towards the infant, early unsatisfied needs of infants.
the mothers, moments of meeting in the therapeutic interactions, the power of the peer group, and the group functioning as a mother’s lap.

**Preventing negative projections onto the infant**

Pregnancy involves drastic changes in a woman’s mental life, and often breaks down familiar defences, allowing aspects of the unconscious world to be revealed and creating new experiences. Women do not merely go through a reorganisation of their mental life, but create an entirely new personality organisation (Fraiberg et al., 1987; Stern and Bruschweiler-Stern, 1998). The mothers in our therapy groups had often used drugs during pregnancy, either at the very beginning, occasionally or throughout the pregnancy, thus compromising their unconscious world. It is of utmost importance that the therapy should enhance new mothers’ ability to process the feelings, thoughts and conflicts evoked by pregnancy. Recalling childhood and revisiting defences is important, because the mother who is preoccupied with her own emotional problems can easily transfer her distortions onto interaction with the infant (Fraiberg et al., 1987; Stern, 1998a). In the group, a special space is created where the past can reappear in the here-and-now interaction. Past emotional conflicts are relived and perhaps understood in the transference, the group process and mother–infant interaction, allowing the discovery of new solutions to old problems (Molnos, 1995).

Our data on mother–infant therapy provide examples of how a traumatic or emotionally deprived past interferes with mother–child relationships among substance-abusing women. Fraiberg et al. (1987) called these past painful experiences ‘ghosts’, and noted that unresolved conflicts and trauma in the mother’s infancy could often explain the occurrence of her infant’s symptoms. The intimate bodily dialogue between the mother and infant may provoke powerful affects, some unconscious, which the mother risks projecting onto the infant. Pleasure in the baby within the therapeutic group process can help a mother become aware of the dysfunctional defences that she has had to create in order to protect herself from frightening early experiences. These might include identification with the aggressor, splitting and projection. The uncovering and interpretation of the unconscious can neutralise their power, provide the mother with a safe place and protect the child from her unconscious projections (Watanabe, 1996). When the ‘ghosts have left the room’, the mother becomes the protector of her child against the repetition of her own troubled past (Fraiberg et al., 1987).

An important focus in the therapy is to link the mother’s early experiences of nurture to the current interaction between her and her baby. By stimulating early unconscious memories, the group provides material and experiences for new internal representations (Larney et al., 1997). Experiences with the therapists make it possible for the mothers to attempt to repair negative representations of their own mothers. Success with the baby can improve internal representations of themselves as mothers. There may be double identifications – the therapist and group members may identify with both the neglected child in the mother and with her real child. Our experience shows that interactions within the group and with the baby can also evoke traumatising experiences from the mothers’ pasts, as illustrated in the vignette below.
Clinical vignette no. 1

a) Mary is angry, demands a lot of attention from the therapists and ignores her baby. The therapists try to calm her down and ask her to tell them what has happened. She describes how her baby’s fingers had clung to her hair at home, and how it caused a strong reaction in her: ‘I lost my temper and I remembered how my mother dragged me by the hair with my feet 10 cm from the ground. I left the baby crying and I went to the balcony for a cigarette to calm my nerves.’ Later on Mary describes, ‘The things from childhood just flood into my mind, and disturb my concentration. Can a body remember? How I was exposed to something really evil.’ The therapists address the entire group. We discuss how important it is that the mothers learn to recognise and control their feelings and reactions well enough to prevent these from being passed on to the child.

b) Linda always feeds her baby with unheated milk. During lunch we discuss the memories that the mothers have of food when they were little children. Linda finds a connection between the cold bottle and her childhood experience. She remembers how her own mother and baby-sitter forced her to eat and drink food and liquids so hot that her mouth was burned over and over again.

Early unsatisfied needs of the mothers

Analysis of this group shows that only mothers whose own emotional needs are met and early frustrations recognised can satisfy the needs of their own infants. The more deprived the mother has been in her early childhood and the longer she has used drugs during the pregnancy, the more important it is to listen to her experience as a child. Like Luthar and Suchman (2000), we observed that at the beginning of the process, the mothers were often so needy that they had to be ‘fed’ first. In addition to listening to, identifying and interpreting a mother’s needs, an important symbolic way of feeding was the concrete pleasure of good food. During the therapy, some mothers realised that they had untreated eating problems and lack of body control; others put on weight.

Clinical vignette no. 2

Julia is a four-month-old baby girl, whose mother Ann is neglecting her needs. Even in the winter in the freezing cold, Ann dresses Julia lightly and gives her too little milk from a dirty feeding bottle. Ann is always very hungry and greedily eats the food that is served in the group. In the first sessions the therapists allow her to concentrate on her own needs, but gradually they and group members express their worry about the adequacy of Julia’s feeding and the warmth of her clothing. The therapists make a whole group interpretation of the mother/infant ravenous hunger and unsatisfied need, and how Ann very clearly expresses group members’ hunger for the group’s care. Other members of the group have already discreetly taken responsibility for the situation. In the following session one of the mothers brings her own baby’s nice warm clothes for Ann, who proudly puts them on Julia. The other mothers show how they prepare milk and gauge their babies’ hunger.
Ann feels that the group has understood her and appreciates her, and she accepts the advice. She soon dresses Julia warmly, gives her more food and holds her more closely. Gradually, Julia’s weight increases, and her interaction with Ann becomes more active, to the extent that Ann complains that she gets tired of Julia’s liveliness.

The therapists observed carefully and were aware of the mothers’ emotions and body language. They looked for signs of fatigue, illness, violence, drug use and variations in weight or skin colour. Therapists often asked how they could help the mothers feel comfortable. Many liked to be covered with a soft blanket and touched gently. The therapist needs to be aware of mothers’ experiences of being touched, and be sensitive to their reactions. Body language is often very revealing. When discussing unusual reactions and bodily fears, some mothers in our groups realised that they had been sexually or physically abused while using drugs. There were also those who suspected that they had suffered from childhood sexual abuse but had not received help or competent assessment.

Attachment, dependency and identification with the group are signs of how group participation can satisfy early needs. Women reported that they missed the group, and said, for example: ‘We have been sick, really. This group is the highlight of the week. It helps us to endure the greyness of the whole week. We have become group addicts!’ They would talk about missing their own mothers’ care and nurture, because it had not been adequately available or too enmeshed. They would wonder if the therapists were caring parents, who did not leave their children too early. They hesitated to fall into the group lap, fearing disappointment at the prospect of the ending of the group. When experiencing the ‘lap’ feeling, mothers had the courage to open up about sensitive situations and recognise their feelings of weakness when facing the responsibilities of a single mother. Fear of abandonment was present when they asked what would happen if they did not have the strength to live and take care of the baby. They asked what would happen if they found themselves battering their baby as their mothers had, or if they were to use drugs again or commit suicide. The fear of losing their child was overtly and covertly powerfully present in the group narratives.

With growing dependence on the group, the mother starts to perceive and experience the baby’s dependence on her as a mother. As stated by the therapists, ‘As you are allowed to be dependent on the group and on us, you seem to be able to bear the dependency of your own child.’ One mother responded with, ‘During the ending of the group, I found that I could manage better and am no longer so dependent on the group or anyone else.’

Moments of meeting in authentic interaction

Stern and colleagues (1998) suggest that the healing power of psychoanalytic therapy lies in a ‘new understanding of something more’ which is different from symbolic and verbal interpretation. Healing is possible when there is an authentic person-to-person
connection, called ‘moments of meeting’ between patient and therapist. Authentic interaction can create new mental organisations or reorganise a patient’s implicit procedural knowledge. This, in turn, affects her way of being with others, understanding and maintaining intrapsychic and interpersonal activity. ‘Moments of meeting’ are used either without or in addition to the analytic technique, and they are possible only in situations that are personal, shared and exponentially new (Stern et al., 1998).

In our groups we utilised ‘the transference of good grandmother’ and emphasised the mothers’ resources and positive assets more than psychopathology and conflicts (Stern, 1995). Mental integrity develops if love for other human beings can overcome destructive impulses. Then the internalised ‘other’ can reveal and free up genuine individual needs and decrease the projections that impoverish mental life. Good and compensatory experiences can neutralise anger towards others (Klein, 1984; Segal, 1988). Grinberg (1990) emphasises that if the therapist is internalised with love, this can affect the deep levels of the self, even within the tissues and organs of the body. Research in neurobiology and early parent–infant interaction has revealed the psychophysiological mechanisms through which comprehensive psychotherapeutic change works (Siegel, 1999). Early human interaction shapes the neural connections from which the conscious mind emerges. Later in life, changes in neural connections can be activated as a result of a particularly strong emotional experience within a single relationship, for example in psychotherapy or between mother and infant. We believe that therapy can strengthen or compensate for the patient’s earlier experiences and thus catalyse an internal resonance. This may be at the core of an integrating process which permits emotional regulation (Siegel, 1999).

These substance-abusing mothers typically carried their terrifying past experiences into the therapy, and it was imperative to find good new experiences in both themselves and other people. Our aim in the therapy was to encourage frequent ‘moments of meeting’ in which mothers could experientially construct new representations of their implicit memories of early painful experiences and distorted dependence. Identification with the therapists and other mothers was reflected as change in their interaction with their babies, which in turn increased the babies’ satisfaction and well-being.

Clinical vignette no. 3
Laura tells of her relationship to her baby in the womb: ‘If I tried to keep off the drugs I had terrible fears and guilt that I had harmed it. I watched it all the time, its development and movements. I did not dare to get attached to the baby or even have a look at him after the delivery, until someone else had checked him carefully for malformations.’

Laura was forced to stop breast-feeding after five months, during her child Andrew’s brief hospitalisation. Laura’s fear of losing her mind was activated in the group. She feels strongly that she has failed Andrew, and is afraid of having a breakdown and losing him. The therapist asks what kind of fantasy she has about
the way her mother nurtured her in the early months. Laura describes in detail the extreme circumstances they lived in, and how her mother began to lose her mind when Laura was one month old; she was placed in a children’s home. Laura is afraid of repeating the fate of her mother. The therapist summarises the similarities and suggests multilevel activation: Laura’s fear that Andrew is feeling deprived may activate in her some small baby feelings, but on the other hand Laura is afraid of losing her adult mind. What is different, however, is that now she is in touch with her emotions and the group is sharing her experiences and emotions. This helps her and the other group members to meet deep and fearful emotions from the past. Laura cries.

In the same group session, Andrew looks depressed. His state of mind seems to correspond to his mother’s mood when she was placed in the children’s home. The whole group concentrates on Andrew. After receiving attention from the group, the baby boy appears to cheer up. The therapist observes to Laura how breast-feeding had helped her to develop a fragile relationship, which seemed to be at risk because she had had to stop it. Laura is unable to make eye contact with the baby. The therapists console and encourage her and show her how to keep Andrew close to her breast and skin. In the next session Laura is calm. She says that she has sung a lot to Andrew during the past week. Contact between them is considerably better and the baby is more alert and active.

During the final sessions of the group, Andrew shows a strong attachment to his mother, and Laura responds positively to this. She holds the baby gently in her arms and looks at him calmly. She says that she enjoys the newly found contact with her baby. She has learned to feed him from a feeding bottle, just as if she were breast-feeding. Laura holds Andrew gently against her breast. Tears stream from Laura’s eyes. The baby falls asleep and looks happy in his mother’s arms, and she does not tire of holding and gazing at her baby. All the women in the group, mothers and therapists, are weeping.

Power of the peer group

The curative factors and healing mechanisms in mother–infant group therapy lie in the comprehensive processes of generating feelings of hope, universality and altruism among the group members (James, 2004; Trad, 1994). The group provides the mothers with opportunities to experience relationships with peers, practice new modes of interaction and achieve a coherent sense of identity through these relationships (Foguel, 1994; Trad, 1994). The mothers in our groups appreciated the presence of their peers in their healing process. They felt that only mothers with substance-abusing experiences could share their overwhelming feelings of guilt and shame, and understand what they were talking about. Shared past experiences made it possible for them to talk about their fears, worries about the future and despair at having caused damage to their child. They were very aware that they were at risk of being socially isolated when they kick the habit, because they have to leave their old friends and even partners in order to create new relationships in a non-drug-using culture.
Clinical vignette no. 4

a) As the group process advanced, we noted that the mothers were increasingly able to tolerate and appreciate observations and interpretations of themselves from the other members of the group. For example, during the early sessions of one group, Sarah describes her drug addict mother, and how Sarah herself was deprived of maternal nurture in her childhood. The other mothers become anxious and restless, and one of the mothers puffs: ‘You are doing the same to your baby that your mother did to you.’ Sarah does not comment, but does not deny it, either. The therapist states how, through Sarah, the group has got profoundly in touch with the reality of what it is to be a child in a family of drug-users. Through Sarah others are able to experience the fear and anger that they felt as children. Another mother adds that every mother, including Sarah, has a desire to guard her children against the negative intergenerational transmission of family problems.

b) In another group, we discuss Vicki’s drug relapse and its consequences on her own physical health and her baby boy’s well-being and development. The therapist interprets that perhaps she did it on behalf of the whole group, because in the previous session Kathy had expressed a strong fear of succumbing to drugs. The group-as-a-whole interpretation gently alleviates the guilt of all the mothers, as well as their fear and anguish. Kathy listens carefully and states gravely: ‘It sounded so horrible, what happened due to Vicki’s relapse, that I cannot just go and take drugs. I mean, I do not need them!’ In one of the groups, Susan vents her rage towards her peers about the way drugs have been found in her urine. Susan claims that someone has planted drugs in her urine, that Social Services just want to take her baby into care and that she thinks that not even the therapists believe her. The therapists acknowledge Susan’s disappointment and let the group discuss it. All ponder their worst fear – of losing their infants. They picture the scenes and the threats. Many are loyal to Susan due to their deep and painful understanding of her rage. However, in the course of a long discussion, they agree that drug screening is principally to serve their rehabilitation and protect their children. On the same day, Child Protection has to take Susan’s two-month-old child temporarily into care, and Susan is taken into residential care. Regional co-operation enables the mother–infant dyad to continue with the group to the end and Susan has the full support of the group.

The group as a mother’s lap

The group can be analysed as a matrix, which James (1984) has defined as ‘a place or medium in which something is bred, produced or developed’. The group as a global object acts as a strong transference trigger for early mother-objects (König and Lindner, 1994). If successful, group members perceive the group-as-a-whole as a maternal image at the deepest level, as the inside of the mother and the ‘mental womb’ (König and Lindner, 1994; Mitrani, 2001; Scheidlinger, 1982). According to our experience the group-as-a-whole can provide deprived mothers with a safe haven, a mother’s lap, which can enhance the integrative healing process.
Our mother–child group therapy accords with the ideas of Foguel (1994), who suggests that the first six months of a group may be comparable to early development in infants. In the beginning, psychic responses are experienced predominantly bodily and the mothers’ main concern is to feed the infant and secure the experience of nourishment and satisfaction. Foguel makes a comparison between a mother’s arms and the group: the group circle contains the space in which group communication models evolve. ‘The second attachment to the mother’ helps the group member to find her valued and beloved true self. She should no longer be afraid of dependence, and independence does not mean abandonment (Foguel, 1994).

We observed these developments in our mother–infant groups. There was an overwhelming ‘greediness’ for nurture at the beginning of therapy sessions. The therapeutic work revealed mothers’ expectations of the therapists as omnipotent mothers, who understand a child’s needs without words. The mothers in our groups were allowed to be small, wordless and dependent on the greater group. The group setting creates an atmosphere and state of mind of shared safety, and thus enables gradual verbalisation of experiences and emotions, enabling mothers to repair early painful experiences. Mothers are empowered to learn different ways of coping with their infants’ difficulties and enjoy motherhood.

One of the important tasks of the therapists and the group is to calm the mothers, so that they in turn are able to soothe their infants. The therapists created a cosy room for the mothers, even laying down mattresses on the floor. According to the mothers’ wishes, we listened to or sang lullabies, children’s hymns and nursery rhymes. We helped the mothers to find just the right position using pillows, and we covered them or wrapped them in a blanket. Occasionally we made a nest for a mother and her infant. We attached great importance to eye contact and we carefully noted the mothers’ and infants’ reactions and responded to them.

It was typical for a session to begin with a mother being nervous and ‘over-filled’, pouring out her anguish and anger over the therapists and the group. Gradually, after being heard, understood and comforted, the mother was soothed and calmed. The group could easily identify with her feelings of being bewildered, in need and fearing abandonment. The mothers eagerly participated in the experience of dispelling the anguish. Typically, during the last moments of the session, the mothers and infants were satisfied and enjoyed being together. At that time we could concentrate on wondering at and admiring the infants and their development. We often noticed the infants fall asleep, and sometimes the mothers as well. Often, after the early anguish and unloading, the feeling of lying on the mattresses was like being in a big lap. The therapists had filled up the mothers and the mothers had filled up their infants. We could feel integrity and comfort together, each group member privately and also as a shared experience.

We hypothesise that the calm here-and-now state of mind is important, because the mothers realise that this is what they had been aiming for through their drug abuse. Their experience in the group shows them that this can be achieved through other means. Mothers reported that, from the very beginning, they searched for instant satisfaction with drugs, and fast relief from agony. One unconscious motive for their
drug abuse had been to cover up loneliness and emptiness, and to prevent scary and hurtful experiences and emotions from rising into consciousness. In the therapy, the mothers were taught to feel gratification with the current, here-and-now relationship with the therapists, their babies and other mothers. The aim is for the mother to fall deeply in love with her infant. The mothers call this feeling a valuable treasure, ‘deep-lying-diamonds’: ‘This child has saved my life. I am able to love and be loved, I am invaluable to my own baby and I desire to put my baby’s needs before my craving for drugs.’ If one of the mothers relapsed or even thought of drugs, she would describe how sick and guilty she felt: the love for the infant functions like a moral ‘aversive reaction’.

**Clinical vignette no. 5**
The therapists are worrying about Cecilia during the first group sessions, because she pays inadequate attention to her baby girl, Susan. In the third session, Cecilia says that she put her two-month-old baby into night-care and went partying. In the next group session, the child sleeps for the entire three hours. This reflects powerfully what happens when the connections between mother, child and peers are broken. The therapists state how important it is to seek and find again the connection to the group and the therapists. In the following session, all the mothers wonder if a substance-addicted mother can be a good mother. During the sixth session, Cecilia tells of her fear of losing her baby, because she has been so unreliable. However, she now believes in herself more and enjoys being off drugs and being a mother. Cecilia uses gentle words, kisses her baby, sings and plays with her happy baby girl. The theme of this session is a mother’s experience of ‘getting drunk on being a mother instead of high on drugs.’

**Psychic integration**
There was scepticism around the idea of group psychotherapy with substance-abusing mothers. Drug-dependent clients often have difficulty remaining in treatment and the drop-out rate is high (Camp and Finkelstein, 1997; Luthar and Suchman, 2000). However, there were no dropouts in any of our six groups. The mothers themselves were surprised and enthusiastic about their new thinking and emotional experiences. They gradually became aware of their ability to integrate their past and present, conscious and unconscious mental states, feelings and thoughts. As we understand it, becoming a mother and enjoying both a widening space for their own emotional awareness and the care and safety of the group facilitated awareness and development.

The therapists frequently used group-as-a-whole interpretations when collecting together common themes. The interpretations worked as translations of the emotions and states of mind of both the infants and the mothers. Just as the mother does in the early months of an infant’s life, the therapists put the group’s desires, despair and fears into words, helping alleviate them. The integration of emotions, understanding and behaviour first occurs in the group and then it also becomes visible in the individual members (Foulkes and Anthony, 1990). For example, it may happen that in the first
sessions there is a shared split, with one member representing the good and the other representing the bad (Klein, 1984).

The breaking of habitual dysfunctional defences in a safe place is especially helpful for substance-abusing mothers. In the group they are capable of realising both their own unique and their shared reasons for substance abuse, which are often related to dysfunctional defences aimed at protecting them from painful experiences and conflictual feelings. This realisation often opens the road to experiential and emotional understanding of the reasons behind the drug abuse. In therapy one cannot change the past but with the help of mourning one can change one’s life narrative and feel that one can have better control of the mind and of life. With our mothers, the more time that had passed since the drug abuse, and the more flexibly the mother could use her ego defences, the more easily she could master her states of mind.

Input from other group members helped mothers to face painful memories. For example, in one group three mothers realised that they had experienced bullying in their school years, and eating disorders and panic attacks in their adolescence. They learned that these experiences had stuck in their minds, limiting their capacity to be available to their infants. The onset of the psychic integrative process involves feelings of security within the therapeutic setting. Some mothers had faced numerous losses and neglect, and therefore the end phase of group therapy had a particular meaning. It provided rich material for interpreting feelings of separation, loss, rage and abandonment (Molnos, 1995). We gave a lot of attention and time to the theme of separation towards the end of the group, and to the transitional period after the group. A specific individual follow-up plan was made with each mother’s immediate social network. In most cases one of the therapists continued to work with the mother and baby for three to ten months, until their life situation was more balanced and follow-up treatment had started. In the best case scenario, a mother enjoyed learning about herself, could mourn the past and could then reconstruct new representations of herself as a mother. Follow-up opportunities vary: day care centre, home help, family therapy, mother–child therapy, individual support or intensive psychotherapy. Combinations of these are also possible.

**Clinical vignette no. 6**

Emily describes the role of her drug use in youth as a medicine to anaesthetise her feelings. ‘When I had speed [amphetamines], I felt healthy. When I was not on drugs, and now afterwards, I felt that everything was sick: my mind, the whole world of narcotics, sex, being abandoned and abused and those horrifying memories and fears.’ She describes the nightmare of waking up clearheaded to chaos, realising that she had moved from being a problematic adolescent to the mother of a small baby. In that realisation she had to face her tormented internal self. She says: ‘New things come into my mind all the time and I am so confused by them. I know I am going where I can find my true self, but the help must be complete and long lasting. This is my last chance to repair those things that led me to use drugs. If I do not solve my problems, I will start using again and lose my baby.’
Conclusion

Analytic group therapy seems to be a promising form of therapy for those substance-abusing women who are able to commit to the group and form a treatment alliance. The selection criteria for the groups are of particular importance. Every group member should be sufficiently motivated to attempt to stop using drugs and work with the causes of her drug dependence. If the mother is still an active drug abuser, refuses urine analyses and/or uses strong denial and splitting defences, the resistance and negative transference in therapy may inhibit the work of the group (Bion, 1975) and even destroy the opportunities for other group members to make use of help. Drug relapses are, after all, common in groups where the members are in the recovery process. It is important that these members work on their relapse and accept the support of the group and the network.

We assume that the mothers’ strong commitment to the group process can be attributed to three issues: the therapists’ commitment, availability and faith in the participants’ mothering capacity; the symbolism of the group in terms of belonging and strength; and finally, the acknowledgement of concern for the well-being of the infant.

One of the therapists should also agree to remain involved with mother and baby, until they feel safe enough to leave and start work with the next worker. The ‘second attachment’ to the mother-group with its unique experiences helps the drug-dependent mother to find her valued self. She is in touch with her emotions and has experienced the start of a psychic integration process, the precondition for psychic growth.

The therapy group can function as a diagnostic assessment tool for detecting problems in early dynamics between the mother and infant. First, it can reveal how the mother was cared for in her early childhood. If this care was good enough, the mother can more easily enjoy her own motherhood and act as a good model for other mothers in the group. The more deprived the mother was in her early care, the more important it is that the peer group and therapists offer her a safe environment in which to learn new ways of interacting. Second, the group can uncover the gravity of the mother’s drug problem and her stage of recovery. Some of the mothers need temporary residential or outpatient care, during or after group therapy. Third, during the group process the mother may become more conscious of her own mental health problems and the need for medical and/or psychotherapeutic treatment. Finally, it is possible to observe and assess the infant’s emotional and physical development.

There has not been a follow-up study, but we are still in contact with the 15/16 group participants. The latest news concerning the mothers dates from spring 2006: one is dead, three have relapsed, eight are working or are in vocational training, two are at home with the children and two are temporarily out of work. Four mothers have given birth to a new child. In all, 11 of the 16 children are living with their mothers; two are with their fathers and three are in foster care.

Mother–infant group psychotherapy with substance-dependent mothers is a new area that needs further work and research. It is essential in order to understand the dynamics of the attachment relationship between the mothers and their infants, and to provide opportunities to enhance maternal reflective functioning (Reynolds, 2003).
As substance dependence is often comorbid with other diagnoses, it is necessary to understand the implications of maternal mental health.

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