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THERAPEUTIC WORK WITH TRANSGENERATIONAL TRAUMA

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parent-infant psychotherapy
transgenerational trauma

Summary

The work describes, using clinical examples, how working with a mother-child dyad or with a parental couple and a child allows us to stop negative or traumatic intergenerational transmission. Starting from the theory of Winnicott's holding, Bowlby's attachment, and Green's "dead mother" concepts, we describe the formation of a transgenerational message. We deal with the transmission of relational trauma, consisting in such an interaction between parents and a child, in which the attachment figure becomes a source of threat. Since transgenerational trauma affects not only individuals but most of all relationships between them, we can observe and treat it also in relationships. A special type of psychotherapy is helpful here, known as parent-infant psychotherapy. The sooner such psychotherapy is undertaken after the birth of a new family member, the greater the chance that we will protect the next generation from the transmission of trauma. Working on breaking the transgenerational transmission of trauma through psychotherapy for parents with babies is working on a bond. Important elements of this work are family history and observation. The therapist observes the child's behavior, the parent's behavior, interactions between child and parents, child and therapist, mother and father, and parents and therapist. The observation is accompanied by a comment, thanks to which the therapist helps the family find connections between the conclusions from the observation, information from the family interview, the reported problem, and current and past events in the family. In this way, family members can reunite in a new, non-traumatic way.

Theoretical background for transgenerational trauma

Our therapeutic work is based on psychoanalytical theories of such authors as, first and foremost, Winnicott and his theory of holding, Bowlby's theory of attachment, and Green's concept of the "dead mother".

According to the attachment theory, the infant has an inner instinct for establishing a bond with their caregiver. Trying to satisfy the need for closeness, the infant develops an attachment to the caregiver, i.e. the relationship on which the infant's subsequent interactions and important social relations are based (1). On the grounds of observation of infants' responses to temporal separation from their mothers, four types of attachment were distinguished: secure, anxious-avoidant, anxious-ambivalent, and disorganized. Children representing the

secure type respond to separation from their mother with anxiety, but joyfully welcome her return and promptly resume their play. Children with the anxious attachment pattern are not comforted by the mother's return. Therefore, they adopt either of two adaptive strategies. Namely, they either ignore both the mother's departure and her return, nevertheless remaining constantly in a state of arousal (this style is termed avoidant attachment), or they constantly display angry behavior (which is termed ambivalent style). Both these attachment patterns, secure and anxious, are regarded as adaptive, and aimed to evoke a desirable response from the caregiver. A different type of attachment is the so-called disorganized style, where caregivers not only have difficulty comforting the child (as in the anxious attachment), but moreover, they are a source of anxiety themselves. The child does not know whether they should be driven by the need for closeness (proximity) or rather avoid any contact. An obvious reason for the child's perplexity may be parental violence. However, it turns out that parents' preoccupation with their own trauma may also contribute to the development of disorganized pattern. Such parents are incapable of attuning to the child's needs, they are either excessively withdrawn or overactive, disregarding the needs of their child.

Another important concept regarding transgenerational trauma is that of mentalization. Mentalization is the ability to understand what other people are thinking or feeling [3]. Mentalization theories assume that the ability to conceive oneself as a thinking human being is not inborn but originates from interpersonal experiences. The development of mentalization is related to the child's interaction with caregivers' more mature and sufficiently attuned minds. In other words, children should feel they have access to and can live within the parent's mind. Children who experience secure attachment have more opportunities to practice mentalizing in the parent-child relationship. If caregiving resources are limited and the best strategy is that of anxious attachment, then the child has to monitor their parents' unpredictable states of mind. The child exposed to disorganized attachment does not seek any representation of their mental state in others but is attacked by the caregivers' states of mind and has difficulty understanding those of their own.

In the attachment theory, transgenerational trauma is considered in terms of unspecific problems associated with the traumatized parents' lack of caregiving capacity or with a holding deficit as proposed by Winnicott [4]. According to the author, the infant lacking ego integration is in the phase of absolute dependence on the caregiving object (usually the mother). During these early months, the infant and mother are merged into oneness, and the infant's both physical and emotional development depends on the supportive maternal environment. It is through this environment that the infant's "inherited potential" acts to create a "continuity of self" [5]. Without this environment, the infant would not develop the sense of being a separate object. In other words, the newborn is governed both by ghosts and by angels. The metaphor of "ghosts in the nursery" was coined by Fraiberg to describe parents' mental and affective states which are activated in their relationship with the infant and which disrupt the family bond [6]. Fortunately, the infant is surrounded also by "angels" of good or (as proposed by Winnicott) "good enough" parental care based on the parents' memory (not necessarily conscious) of care they had experienced themselves despite traumatic aspects of their relationships [7].

Difficulties with "good enough" care provided by parents are often associated with their traumatic experiences (first and foremost those of the mother). Thus, trauma is transmit-

ted via the early preverbal relationship to the next generations. Using the "dead mother" concept, André Green [8] made an attempt to reconstruct how this early mother-infant relationship functions. He described a particular type of patient who in an early stage of their life had been in the care of their emotionally absent, traumatized mother. The causes of her trauma remain unrevealed and are kept hidden. The infant initially tries to repair their preoccupied with mourning mother, but the attempts are unsuccessful. The effort is obviously futile since the infant is striving to repair the mother "from the outside", while her trauma is inside. With time, the child begins to realize how helpless they are. These children frequently suffer from insomnia, arousal, and nighttime fears. Defending themselves against a sense of despair, the infant activates defense mechanisms – above all, by decathecting from the mother object and by unconscious identification with the dead mother (analogously to the melancholic process described by Freud).

Green also believes that this type of early childhood deprivation leads to a number of consequences in later life. A person abandoned by the "dead mother" attempts to cope with the traumatic situation by self-realization at the fantasy level, which may promote self-expression through art, or by highly efficient intellectualizations at the cognitive level. These individuals frequently complain of a sense of inability – they report being incapable of withdrawing from a conflict situation, unable to feel love, develop their talents or increase resources. They can never be satisfied, even if they achieve success. It is characteristic of them to experience emptiness, termed by Green as negative hallucination, white psychosis or white mourning. Such experiences result from a massive emotional withdrawal, leaving traces in the form of "psychical holes" in the unconscious. On the conscious level, these people believe that emotional coldness is inappropriate and that they are capable of emotional involvement if they feel loved and accepted. In reality, such individuals are incapable of manifesting love, since their love is "deposited" in the dead mother object. In adulthood, they strive for loneliness rather than relationships. Green's description of a person brought up by a "dead mother" corresponds to that of Kay in the Snow Queen fairy tale. The author points out that these patients constantly complain of cold, as the core of love is frozen by the dead mother. This is not to say that they have no seemingly successful occupational and social life, some of them get married and have children. However, due to conflict re-activation, the two most important aspects of their life, i.e. work and love, turn to failure. Their occupational life becomes disappointing, while their marital relationships lead to severe disturbances in love, sex life and emotional expression. Overfocusing on parental role is frequent, and in many cases strongly influenced by narcissism: children are loved on condition that they attain the narcissist goals their parents had failed to achieve themselves.

The destructive effects of maternal emotional absence were confirmed by Karen Lyons-Ruth from the Harvard Medical School – the results of her longitudinal research on family bonds [9] indicate that the strongest predictor of unintegrated mental states in adulthood is not the mother's hostile or aggressive behavior, but her early emotional withdrawal.

Transgenerational trauma treatment

Is it possible to break the cycle of transmission of intergenerational trauma? How can we grasp something seemingly so elusive, only intuitively apprehended and unconsciously transmitted from one generation to the next?

Since transgenerational trauma affects not only particular individuals, but above all relations between them, it can be observed and treated in relationships. The transmission of trauma may occur in parent-child relationships, but also in separate dyads: mother-child and father-child.

A particular type of therapy seems to be helpful here, namely the so-called parent-infant psychotherapy. The sooner such psychotherapy is undertaken after the birth of a new family member, the greater the chance of preventing the transmission of trauma to the next generation.

Relational trauma is defined as a parent-child interaction producing overwhelmingly difficult emotions in the child. The child's caregiver, i.e. the attachment figure, becomes a source of threat. Fear experienced by the child in the relationship with their parent-caregiver results from the parent's unconscious preoccupation with his/her own trauma, irrespective of the trauma type. Due to this preoccupation, the parent is unable to adequately focus attention on the child. On the contrary, any contact with the infant's primary emotions reactivates the parent's own trauma-related feelings, therefore instead of empathy and an appropriate response to the infant's signals, the parent reacts with helplessness and fear. Such parents are not only incapable of comforting the infant but also feel traumatized by the baby and tend to treat them the way they had been treated by their parents themselves [10].

The parental ability to adequately respond to the child's signals serves as the foundation of the infant's mental health development [11]. Unresolved parental trauma is associated with the risk of disorganizing the child's attachment pattern and passing this pattern down across generations.

Becoming a parent involves the process of grieving for oneself as the child of one's own parents. In the course of this process, identification with one's parents undergoes reorganization, leading to the projection of the unwanted aspects of the parents onto the infant [12]. This applies to every parenting situation, but in the case of transgenerational trauma, the contents projected onto the infant are particularly difficult or damaging. Moreover, the rigid nature of projection mechanisms precludes the gradual withdrawal of such a projection, in contradistinction to healthy family situations.

In the life of any family, the perinatal period is a natural crisis that not every family can adaptively cope with. Trauma experienced in the past returns and demands to be worked through, otherwise it will be repeated in further generations.

The parent-infant relationship begins during pregnancy and even earlier when the parents imagine their future child and mutual relations with them. However, an imagined or fantasized child differs from the real newborn [13]. The parents must get acquainted with their real infant, to see what they look like, to learn what they want, what their likes and dislikes are, what they need and what they are feeling and thinking. The caregivers' conscious and unconscious experiences are the basis of their imagery regarding the child. Unconscious trauma-related communications are sometimes so powerful that it is difficult

for the parent to see and recognize the real child. Under such circumstances, everything that the parents want to get rid of, i.e. aspects of their trauma, are projected into the child. The infant feeling these parental projections begins to behave accordingly [14]. It is difficult for the family to overcome the ensuing vicious circle.

Therapeutic work should include both parents, but if there is no such possibility, then separate dyads, mother-child or father-child, should participate. Including the father in the consultation process and subsequently in therapy is of utmost importance. The absent parent is still present in the other parent's mind and by this token also in the child's mind [15]. Talking about the father's presence in his absence is an important component of psychotherapy [16].

Assistance in the perinatal period is significant not only with regard to the child. It is a particular life stage for both parents and the whole family since at that time unconscious memories and transgenerational communications become activated. Both in the mother and in the father, emotions are reactivated, ones related to care and dependence, to their experiences of being an infant and child of their own parents, as well as by how these experiences have been remembered emotionally (interiorized). Thus, the latter are accessible to the therapist who can then release the parents from participation in the unconscious intergenerational transmission of trauma and all its consequences, not only those concerning the parent-infant relationship [17].

To sum up, the goal of parent-infant psychotherapy is to aid the development of both the child and their parent(s). The patients here are not only parents with their life history and the child but also their mutual relationship. The infant is a rightful patient in this type of therapy. It is owing to the child and through the child that access is possible to what is going on in the family [16].

The frequent reason why families seek consultation for such therapy is the child's symptoms. Because of such symptoms, the parents begin to seek help for their child and by the same token for themselves. The presenting problems often include the child's anxiety, weepiness, difficulty falling asleep, breast feeding or eating, suffering from colic, regurgitation and vomiting, diarrhoea and bowel obstruction. The infant may withdraw from contacts by sleepiness or apathy, may refuse or considerably reduce their food intake, and may be hyperactive or overreactive. This may be associated with avoidance of eye contact with the caregiver, particularly in the case of a mother who has suffered or is currently suffering from postpartum depression or psychosis. In infants over 1-year-old, besides the above-listed symptoms other ones are also noted, including disturbed speech development, withdrawal, temper tantrums and aggressive behaviors (more marked than in the peer group) toward the parents and/or other children and even toward the self [18].

The child signals relational problems by means of their bodily symptoms or behaviors, the only accessible way of expressing their emotions and needs. During consultations and sessions in the course of parent-infant psychotherapy, we strive to find the causes of these problems at a deeper level, connecting the symptoms with what we learn from the parents and what we can note in the consulting room.

Clinical vignettes

In some cases, it is not the child's symptoms that are the reason for coming for a consultation, but rather a family crisis resulting from the parents' difficulty in the transition from being a couple to being a family. Such a crisis may be manifested by the parents' mood swings, quarrels, tendency to escape (e.g. by means of sleep, other relationships, or work) or indifference and withdrawal. Sometimes the parents are aware of their current crisis, but they blame everything on the child. The appearance of the child as a third party may disturb the more or less fragile balance that the parents believe they had in their former relationship.

The source of our case reports is a private practice based on the psychoanalytic approach. Psychoanalytic therapy is also provided by some Community Mental Health Centers for Children and Adolescents.

Many families were referred to us by professionals who had known about the availability of this type of psychotherapy. The referring professionals included mostly:

- family doctors from the primary care facility where the child was seen for postnatal checkups, vaccination or routine health checks;
- a psychotherapist or psychiatrist treating one of the parents;
- the child's physiotherapist;
- nursery staff.

In some cases, parents were informed about the availability of this form of assistance by a member of their extended family or a close acquaintance witnessing the family crisis after childbirth.

As regards infants, some families contacted us after the child had been diagnosed with somatic conditions and submitted to various medical interventions, even hospitalization. The process of differential diagnosis for somatic disorders is often conducted in parallel with psychotherapeutic consultations and sessions. Parents are generally unaware that the child's symptoms may reflect what is going on in the family. It is important to spread information about parent-infant psychotherapy among physiotherapists and osteopaths. For some of the infant patients, a greater problem than their muscle tone impairment is the mother's difficulty with touching and holding the child.

Some families may be self-referred due to a general postnatal crisis.

Case vignette 1

A young married couple came for consultation because of a severe marital crisis following childbirth. The mother could not stand the newborn's crying, since she was feeling tired and not getting enough sleep. She experienced severe anger toward the child and responded with rejection, namely, she refused not only to feed the newborn but also any contact with the baby. In consequence, the father assumed the role of the child's defender, which the mother perceived as an attack against her. Mutual grievances resulted in daily quarrels that made the family seek help.

Case vignette 2

> In another self-referred family, the problem was the father's feeling of being rejected by his spouse after childbirth. The mother experienced "primary maternal preoccupation" [19], quite natural in the postnatal period. It was completely incomprehensible to the father, who demanded her exclusive attention and treated the newborn as a rival.

Both these couples believed the newborn to be the cause of their crisis and considered separation or divorce.

In situations of this type, it is worthwhile to explore what the parents' idea of being a mother and a father is, and what their own experiences of being a child of their mother and their father are. In the first couple, the mother described her childhood experience of being abandoned and neglected by both her mother and her father, whom she remembered as an aggressive man. Under such circumstances, when lacking a good maternal role model, it is difficult not to be afraid of one's own maternity. This woman directed her need for caregiving toward the infant's father and was incapable of appropriately caring either for her newborn child or herself. She adopted a persecutory way of perceiving the child, similar to her perception of her own father in the past – as someone self-centered and disregarding her needs. Her response to this situation was similar to that of her mother's, namely, withdrawing from the family and abandoning her child. This was incomprehensible to the infant's father, who identified himself with the abandoned child, remembering from his childhood his feelings of being abandoned both by his mother and by his emotionally absent father.

The father in the second family had experienced acute fears in his childhood, in his opinion associated with his alcoholic father. He had also felt neglected by his mother, so absorbed with her marital relationship and her work that she had been unavailable to her son. In his adult life, he sought a partner who would satisfy his needs and would have time for him only. The child's arrival was unplanned and unexpected, evoking his severe anxiety and fear of being abandoned. The developments after the childbirth confirmed his worst fears. He perceived the newborn the same way he had seen his father in the past, i.e. as terrorizing the family and taking the mother away.

In both families, separation of the "here and now" from their past experiences, resulting emotions and unfulfilled needs helped them to find their way in the current situation and to feel they were a new family building up their new experiences.

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In some cases, rejection of the child by the mother is associated with her rejection of herself in the maternal role, and by the same token with the rejection of her internalized mother. This rejection may occur also at the body level.

Case vignette 3

A patient who remembered her childhood and particularly her relationship with her mother as traumatic suffered from anorexia in adolescence. In her relationship with her present partner, she had four miscarriages at various stages of pregnancy, with no diagnosed somatic disorder. When she became pregnant for the fifth time, she was so afraid of another miscarriage that she avoided any bonding with her unborn child. After a successful delivery, she began to experience the baby the same way she had experienced her relationship with her abandoning mother, identifying herself with her own mother and rejecting her child. The family's presenting problem was the child's acute anxiety, his unstoppable crying, shallow sleep and unwillingness to eat. In the course of our therapeutic work, the mother was able to explore her childhood absence of consolation and her unfulfilled need for being loved and cared for. Working through her relationships with her own mother and father as well as through other past experiences helped her to see the baby as a new family member who deserved to be known and perceived as a separate person, rather than as an object of projection only. The mother's opening up to her child immediately resulted in the baby's highly satisfactory response to her. She accepted herself in the maternal role, seeing herself as a person entirely different from her own mother. Her former unconscious identification with her mother was a severe obstacle not only to experiencing her own maternity but also in her relationship with her partner as the child's father.

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Somatic symptoms very often are the presenting problem in infants.

Case vignette 4

In one of the families, the presenting problem was severe colic in their four-month-old baby. A preliminary interview revealed the parents were surprised and annoyed that after the first calm months spent eating and sleeping, the baby was presently demanding to be held in their arms. The mother stubbornly refused to comply with these demands, she simply could not imagine limiting her daily household chores such as cleaning in order to adapt to the needs of her child. Moreover, a major problem emerged concerning her physical contact with the newborn son. The boy was bottle-fed with infant formula when lying supine in his cot or being held by his father. The baby persistently demanded physical contact with his mother, available solely when he was crying because of colic. It was the only way, as the boy was then taken in his mother's arms, hugged and stroked. His father did not refrain from carrying and hugging his baby son,

but for most of the day, he was at work away from home. On his return home, both the baby and the mother used to calm down. In the course of consultations, the mother shared her childhood experiences regarding her very strict, cold and strong-minded mother, who had to be obeyed both by herself and her father. Unfortunately, due to her persistent idealization of her own mother, father, and her whole childhood, she was unable to enter the therapeutic process. De-identification from her own mother, completion of mourning after her childhood and her self-differentiation turned out to be too threatening to this patient, despite considerable interest in therapy shown by her husband. Our contacts ended after a few consultations. The therapist was left feeling sad, helpless and abandoned. Similar feelings were probably experienced by the infant in this family, as previously in the past by his mother in her relationship with her parents.

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Difficulties in relationships between infants and their caregivers may cause severe problems with breastfeeding. In extreme cases, the baby may refuse to eat, its metabolism may become considerably slowed down and no other needs are expressed.

Case vignette 5

In one of the families, the presenting problem concerned a child recently discharged from a neonatology department where no medical reasons had been found for the baby's refusal to eat for a few days. During the consulting session, it almost immediately turned out that the mother suffered from eating disorders, and her relation with the baby's father was full of tension and anxiety. In the relationship with her partner, the mother felt scared, lonely, immobilized and hopeless, which might have corresponded to the baby's feelings in the relationship with her. She had experienced the same feelings herself in her childhood relationships with her parents. Her partner also described the difficult history of his still idealized childhood. He unconsciously identified himself with his father, manifesting violent behavior toward his present partner. The baby was expressing the mother's immobilization and her feeling of a lack of meaning in life. Over time, with progress in therapy and working through the parents' relational traumas, the baby became more lively and showed increased appetite. The infant-parents relationship became unburdened by the intergenerational trauma transmission from both sides of the family.

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The infant's symptoms are not always so dramatic and sometimes the parents do not notice their baby's withdrawal into his or her own world. Such families seek therapy usually later, when the child is between one and a half and two and a half years old.

Case vignette 6

A family with an almost two-year-old son came for consultation since the mother, and earlier their primary care family doctor, were worried about the boy's retarded speech development and his avoidance of eye contact with his mother. As early as during a preliminary interview, the mother disclosed that she had suffered from untreated depression with suicidal thoughts for years. She associated her condition with very difficult childhood experiences, and later in life with her relationship with the child's father. Moreover, she felt rejected by her baby, who from a very early postnatal period avoided looking at her even during breastfeeding. The father was initially reluctant to attend our sessions, but through participation he became more present in the life of the child and the family. Both the father's inclusion in play activities with the child, and interpretations associating the child's behaviors seen during therapeutic sessions with contents introduced by the parents turned out to be significant. The father gained a deeper insight into the relationships between the child's symptoms and processes ongoing in the family, which helped him not only to participate in therapy, but also to be emotionally more available to the child at home. The mother gained more space enabling her to take care of herself. She decided to seek help from a psychiatrist and take antidepressants, which helped her to reduce tension and get more out of therapy. She began to initiate interactions with her son, became emotionally more accessible to him and open to his communication cues. She understood how difficult it was for the child to look at his mother engrossed in utter sadness, despair, and hopelessness. She worked through her grief at her lack of adequate contact with the child until the present, while her partner had to process his grief caused by how much he had lost by not participating all that time in the care of his child. It is owing to the connection of the parents' current experiences with their past memories of being neglected and abandoned as children that the attainment of such effects was possible. The child returned to the relationship with his parents not only through eye contact. Additionally, his speech development accelerated.

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In families having more than only one child, each of the children may be treated differently and experienced as an object of various projections.

Case vignette 7

Parents with a two-year-old son came for consultation because of his tantrums and considerable aggression in response to their setting boundaries. The boy had a brother one and a half years older than him. The elder brother was described by both parents and particularly by the mother as an ideal child, who played by himself, demanded nothing, bothered nobody, never picked quarrels and in the worst-case scenario responded aggressively to his younger brother's aggression. In the course of therapeutic work, relational problems of not only the elder brother, but also of both the parents were revealed. The younger sibling demanding attention, requesting to be accompanied in play activities, and expecting the parents to address his needs was experienced by them as an intruder disturbing the family dynamics. According to the mother, her younger son's behavior was similar to that of her mother's father whom she called "the psychopathic granddad" who used to "destroy" her mother and whose needs had to be most important for the whole family. The mother experienced her younger sister in a similar way, describing her as lacking empathy, demanding, and favored by their mother. In the mother's opinion, her younger son inherited the genes shared by her grandfather and her sister. In consequence, she had similar feelings towards him, of resentment, grievance, anger, and sometimes even hatred. The father never objected to this narrative, so the mother's attitude toward the child never changed. On the other hand, the mother strongly identified herself with the elder son whom she perceived as calm, understanding, and threatened by his younger brother's aggression.

This case example shows to what extent the parents' life histories burdened by unresolved trauma can influence parental perception of and relationships with their children. Psychotherapy with this family was very difficult and met with resistance from both parents. They had expected the therapist to change their younger son's behaviors solely so that he would adapt to the remaining family members, while they were not interested in gaining a deeper insight or working through emotions associated with relational traumas and their effects. Nevertheless, it was possible to partially withdraw maternal projections and to increase the mother's ability to perceive and experience both her sons not as figures from her past, but as separate individuals worth knowing and understanding. What was also important was the father's heightened awareness, which increased his activity and involvement in family life.

Summary

All the clinical vignettes are presented here in a very simplified way since full case reports would considerably exceed the scope of this article. In the presented therapeutic work with the family/dyad, the psychoanalytic approach is used involving psychoanalytic conceptualization and tools associated with observation of the child's behavior/

play as well as interactions between the child and each of the parents, siblings, and the therapist. Interactions between the parent(s) and therapist and in the parental dyad are also taken under consideration. All these data are referred to the presenting problem described by the parents as the reason for seeking therapy, and to other information acquired from interviews concerning not only the child's development, but also each parent's life history. The psychotherapists' skill in using their own countertransference is also necessary. Since we are dealing with a preverbal stage in the infant's life and with very primary affective states, countertransference and observation are the main tools in this psychotherapeutic work.

Several traps should be avoided by the therapist. Firstly, the reason why the family has come for consultation may be understood at the level of consciousness and concreteness only, without taking into account any unconscious communications. Secondly, the therapist may persist in unconscious identification with either of the parents or with their child. This may lead to the therapist's trying to be a better caregiver to the child or striving to help one of the parents in the difficult relationship with the partner and the child. That is why the therapist's awareness of countertransference is so important.

Progress in therapy involves the development of parental reflective functions associated with mentalization, increasing the infant's chances for appropriate mentalizing development. Parental motivation for therapy is of importance, as well as their preparedness to enter into a therapeutic process where no ready solutions are available but may only emerge as a result of therapy.

The duration of this process may range from a few sessions to 2-3 years, depending not only on the family's needs and capacities, but also on the therapist's work style and the facility where therapy is provided. The main aim of brief processes is to withdraw parental projections from the child, while longer-term therapy may lead to changes in parental inner self-representations. This depends not only on the process duration, but also on the frequency of sessions and on the parents' psychopathology.

Our goal was to present the mechanisms of intergenerational trauma transmission and the possible effects of therapeutic work on either breaking up or considerably reducing the transmission. Unresolved trauma of a parent and frequently also of his/her parents or even grandparents results in the passage of the disorganized attachment pattern from one generation to the next, and in a considerable risk of further intergenerational transmission of this trauma. The parents' childhood experiences influence not only their relationship with the child but also their mutual relationship as partners. The perinatal period crisis gives the family a chance to work through emotions associated with the unconscious transmission of trauma. Since it is at this stage that primary emotions related to care and dependence are activated in both parents, their trauma unconsciously transmitted across generations is more accessible to the therapist than it would be in individual therapy.

Marta Badoni (20) points out the risk of being stuck in an intergenerational obligation when parents despite their coming for therapy are not interested in going beyond an apparent equilibrium based on their relationship with the child as the object of their projections. Since the psychological birth of the child is threatening to both parents' defenses, they adopt a system in which they unconsciously become siblings seeking a way for an impossible reparation. Thus, they perform a "narcissistic scenario" and are unable to recognize their

child as a separate person [21]. Espaza [12] describes several types of parental narcissism and their implications for treatment in terms of parent-infant psychotherapy. Manzano [21] writing about the intergenerational transmission of parental narcissistic scenarios in the context of the parents' influencing the child, but also vice versa, emphasizes the significance of the therapist's countertransference in the work on the transmission of trauma. The role of psychotherapists' consciousness and their capacity for countertransference utilization in parent-infant psychotherapy is highlighted also by Thomson-Salo [22]. Countertransference helps to understand the infant's inner state and the family's situation.

Moreover, Badoni [20] deals with the risk of the traumatizing effects of intergenerational obligation in the form of cognitive impairment in the infant who is incapable of self-differentiation and their own identity development. Parents are interested more in eliminating their child's symptom rather than in gaining a deeper insight into what is going on in the family and seeing the symptom as a result of delegating the child to a task too difficult for them and unresolved by its parents or grandparents. The effects of even brief psychoanalytic interventions for children under 5 and their families are discussed by Maria Pozzi-Monzo [23]. The interventions were helpful in the parental shift from reactive to more reflective states of mind (and more reflecting toward the child).

Work on breaking up transgenerational trauma by means of parent-infant psychotherapy is focused on bonding. Important constituents of this work include family interviews and observation. The therapist observes how the child and the parents behave and how each of them interacts with all the other session participants. Observation is accompanied by the therapist's commentary, helping the family to connect conclusions drawn from observation with information obtained from the family interviews, their presenting problem, and with both current and past events in the family. This enables the family members bonding in a new way free from trauma.

The focus of this article was on working with infants. We are not sure whether the families presented in case vignettes in crisis situations will return to their old, well-known patterns. Hopefully, their positive therapy experiences may encourage them to seek this sort of support in the future.

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