

# *Finding Hope in Despair: The Story of Charlene and Jay*

By  
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Winnicott (1960/1980) famously reminded us “there is no such thing as a baby.” The parent or caregiver is central in the infant’s world and well-being. However, there are times when the interpersonal world of infant and caregiver becomes fraught with conflict and miscommunication, times when the needs of the mother are in conflict or in competition with what her child needs for healthy development.

I have chosen to write about Jay and his mother, Charlene, because our work with them painfully illustrates the dilemma and difficult-to-resolve therapeutic challenge of keeping the needs and experience of both infant and caregiver in mind without being drawn into the sometimes destructive drama being played out between them and without colluding with one against the other. In our work, as a team of two therapists working with Jay and his mother, this difficulty became intensified rather than being highlighted and better understood.

For the relationship between mother and infant to be “good enough” and to serve the infant’s healthy development, the loving feelings must outweigh the hateful. The loving and mutually satisfying shared experiences between mother and infant must outnumber the hateful and painful experiences of misattunement, miscommunication, and misunderstanding.

When the mother is feeling that her baby is telling her she is not good enough, how can she manage to stay present to the baby? What happens? The mother may protect herself from the unmanageable or threatening experience in some way, by cutting off from the raw feeling, distancing from it psychologically, or dealing with the

threat to self by externalizing it and blaming someone else. Sometimes, she blames the baby. Charlene’s pursuit of a diagnosis to explain Jay’s behavior and developmental delays brings into sharp focus the inherent tension in all therapeutic work between assigning a diagnosis and seeking a dynamic understanding of the child’s experience of the world and his parent’s experience of the world.

That the infant has a mind and seeks to make sense of his world through interaction with the minds of others informs all of my clinical work. Charlene’s need for attention and narcissistic bolstering made it seemingly impossible for her to put Jay’s experience and his imperiled development at the center of the treatment. She saw and experienced Jay as a burdensome child, difficult and damaged. Charlene had come to believe that Jay “had autism.” To her this meant that Jay had “something wrong with his brain” that rendered

him unable to love and be loved like “normal children.” She held little or no hope for Jay’s development, and saw him as destined to a life of impaired communication, robotlike interaction, and bizarre—at times “out of control behavior”—that made no sense. Charlene believed that Jay’s behavior was determined by his biology, and that there was little she could do except be supported in learning how to “manage him.” Reputedly, her belief was shared by Jay’s grandmother and by one of the staff at the child care center Jay attended for many hours every week.

Charlene’s conviction that Jay was autistic had prompted her to seek eight assessments for him prior to our involvement. He had been assessed by three different pediatricians, working in different parts of the health service, as well as by a developmental psychologist, two speech pathologists, an occupational therapist, and a physiotherapist. None

## *ZERO TO THREE Corner*

*The Center on the Social and Emotional Foundations for Early Learning (CSEFEL) is a federally funded national resource center designed to support early care and education (ECE) providers in addressing the social-emotional needs of children birth through age 5. Recent research has found that an extraordinarily high number of young children are being asked to leave early childhood settings because of their behavior. In the article below, the authors describe the Pyramid Model, a framework of recommended practices to help ECE programs support the social-emotional competence of young children and address challenging behavior.*

Therapeutic intervention with children and families is not always successful, but the professional literature does not often address treatment failures. Yet all clinicians at one time or another will face challenging cases and disappointing outcomes. To address the need for more information about how to handle challenging cases, *Finding Hope in Despair: Clinical Studies in Infant Mental Health* (edited by Marian Birch, published 2008 by ZERO TO THREE) explores the limitations of infant–parent psychotherapy by examining six different “treatment failures” using a unique format for reflective discussion. The author of each case study provides the facts of the case and the feelings generated by the failure of the intervention. Each case study is followed by a chapter of analysis by another clinician who offers insight on the lessons to be learned from the case. The following article is excerpted from a chapter in *Finding Hope in Despair*.

found his presentation consistent with a diagnosis of autism. Jay's hearing had been assessed; concern about his excessive dribbling had been investigated. Many organic illnesses had been explored and excluded.

The third pediatrician who was asked to assess Jay became alarmed as she gathered together all of the information available in the hospital and outpatient charts. She was concerned that Jay's frequent presentation to health services was communicating something important that needed to be thought about. She referred this troubled mother and son to the Mental Health Services to see if they could help Jay and his mother make sense of what was happening in their family. Despite the findings of previous assessments, Charlene held onto her belief that Jay had autism. I suspect she hoped the Mental Health Services would see what others had not.

My first meeting with Jay was when he was 26 months old and his mother brought him to a hospital Mental Health Services department, where I spent time consulting. Charlene and Jay alone came to the appointment. A child psychiatrist in training was assigned to meet Jay. He had limited experience in assessing children under 3 years, and asked that I join him for the interview.

My colleague and I discussed how we would cofacilitate the assessment. It was agreed that he would primarily engage with Charlene, focusing on her story and observing her and her interactions, and I would engage primarily with Jay, focusing on his story and observing him and his interactions. One of our goals for this initial meeting was that both Jay and his mother would experience that they and their story were important to us.

After introducing himself to Jay and to Charlene, my colleague engaged Charlene. He was warm and sympathetic, listening thoughtfully and asking pertinent and important questions. Engaging Jay proved more difficult. We heard that from the time Jay was 2 months old, his young mother, just 19 when he was born, had taken him to many professionals for consultation. She was "worried about him." She wanted to know

"what was wrong with him." Since birth, his mother said, Jay slept poorly, he fed and gained weight poorly, he responded and interacted poorly. She thought he was "angry and irritable with her." She believed her young son "hated her."

In telling us that she believed Jay hated her, Charlene was alerting us to something very important about her experience as Jay's mother. I wondered if she needed her son to carry her hate, and whether her belief about Jay's feeling toward her was a replay of the hateful relationship she had had with Jay's father and the heartbreak she experienced when her own father left "without saying good-bye" when she was 2 years old. Might she not have felt that he hated her too? What I did not think about was that Charlene might have firmly closed the door on the possibility of a loving connection with Jay.

Jay sat on the floor where his mother placed him. He was stiff and seemingly lifeless. He had no curiosity for the array of toys that were available to him, and he made no reference to me. He did not return my gaze, and seemed not to register my greeting. Indeed it seemed that I was not there to him, and that his mother was right in that Jay was not present to the world around him.

I was undeterred. I continued to talk to him quietly, commenting and translating into simple language for him aspects and themes of the dialogue that my colleague and his mommy were having. My interest in Jay was not dependent upon his interest in me. I could wait quietly, undemanding in my expectation that, given time, his curiosity and interest would be aroused by my interest in him and his experience.

Toward the end of the interview, Jay made a few furtive glances toward me. He looked from the corner of his eye. His face did not register any emotion. However, as they were leaving, he briefly looked directly at me and said, "bye-bye." His mother was delighted, saying proudly that she had just taught him to wave good-bye. My heart sank. Charlene's claim to the one meaningful communication that Jay offered in our first meeting was an ominous indication that perhaps

she experienced his accomplishments only in terms of their narcissistic value to her as an accomplished mother and not in terms of any empathic understanding of Jay's experience or wish to communicate.

Perhaps the most striking thing from this first meeting was how utterly enchanted my colleague was with Charlene. He was full of sympathy for her and very concerned about how she could manage Jay's "difficult behavior." He found her articulate, thoughtful, and "clearly a very concerned mother." The Jay alive in his mind—demanding, destructive, and difficult—was very different from the Jay I had been with. His enchantment with Jay's mother was at odds with my impressions of a needy, preoccupied, and self-absorbed young woman whose own needs seemed to leave little room for the needs of her child. My colleague and I had met a very different mother and a very different baby.

Jay's father, Errol, was absent from his life. He had been a heavy drug user, mainly intravenous amphetamines. Charlene reported that Errol's behavior was erratic and at times extremely violent. She said Errol's violence escalated after Jay was born. She finally left him, taking her son home to her mother. Charlene said Jay suckled at her breast "for hours." Errol would become enraged by this. On the occasion that precipitated Charlene's departure, she said Errol had grabbed Jay from her breast and flung him onto the bed beside her. She was shaken and shocked, and left quietly the following morning.

By contrast, her new partner, Al, she said, could not do enough for her. When asked about his relationship with Jay, she replied, "He loves Jay." This was at odds with her reporting how she once took Jay to the local hospital demanding some respite from Jay's constant demands and neediness. At that time, Charlene had explained that Al was at the end of his tether. He was threatening to leave her unless she could "shut the kid up." Charlene told us she hoped to have another baby, and believed that Al would be a "wonderful father."

I was left with many concerns. My colleagues who had previously

assessed Jay had identified problems in his relationship with his mother; Charlene and her son were clearly not relating well. My colleagues had noted the violent and traumatic early months, and suspected that Jay experienced posttraumatic symptoms and was extremely anxious. They noted developmental delays, particularly in his communication. Jay's expressive language was rudimentary, but he was building his vocabulary slowly and using the words he did have appropriately, sometimes using two and three words together. He articulated poorly and was sometimes difficult to understand, although his jargon had a communicative prosody and was thought to be used contextually and appropriately. Jay often seemed to "phase out," and his attention was variable. At times, he was difficult to engage. His receptive language was assessed as being disrupted by his variable attention, but he was observed to respond appropriately to simple requests and to follow the conversation.

After my meeting with Jay, I thought his flat, lifeless presentation suggested he might be seriously depressed. Charlene certainly seemed motivated to "get some help," and was rightly worried about how she would manage when she had another baby.

Charlene and Jay were offered a place in an infant mental health program where I also spent time. Charlene and Jay were told that the program would focus on helping them relate more enjoyably with one another, and that we would collaborate with them and all the other people and agencies involved in supporting Jay's development. Charlene seemed keen to come. However, just prior to the first appointment, she telephoned to tell us that the family was moving to a town 100 miles away because Al had a new job. I did not meet Jay again for more than a year.

Then, out of the blue, Charlene telephoned and asked if she could still bring Jay to the program. Charlene had put on a lot of weight, and she looked pale and tired. Jay too looked pale and tired. I greeted Jay and reminded him we had met before, saying it was "a long time ago, when you were much younger; you have grown." He stared at me wide-eyed

and quizzical, seeming to listen, but he did not respond in any discernable way.

Over the course of three assessment sessions, Charlene explained she had walked out on her relationship following her discovery that Al had begun a sexual relationship with a woman at his new place of work. She said Al had become increasingly cool, preferring to spend his evenings with this woman than to be with Charlene and Jay. She said he seemed to have lost interest in her, adding, "he was never very interested in Jay." Charlene had returned to the city. She and Jay were again living with her mother until she could find "something that would suit them."

Charlene was hurt and angry. She felt overlooked and discarded by Al. Where once she had spoken of him only in glowing terms, now it seemed he was without any positive attributes. With the force of her anger and disappointment focused on Al, Charlene seemed softer in her concern about Jay. This may have been because she could "blame" Al, which gave Jay some respite.

Charlene now reported that Al had "never liked Jay", a very different story to the one she offered at our last meeting. She said he was very cruel to Jay, particularly when he had been drinking. Charlene reported he had been physically and verbally abusive of Jay. She said that Al would taunt Jay, ridicule him, physically provoke him, and then laugh before becoming angry. Al would hit Jay if he lashed out or became angry in return.

When asked what she had done when this behavior was occurring, Charlene replied that sometimes she would join Al in taunting Jay. She added, "I should have stopped him, or reported him for child abuse." I wondered what stopped her and if Jay was offered up to Al's violence as a way of protecting herself. Despite the anger she was now feeling toward Al, Charlene described a perverse coalition of parental figures against the child in saying that she sometimes joined Al in taunting Jay. I wondered if there was ever a time when Al had joined with Charlene in an alliance in which together they could think about Jay and his needs. It seemed unlikely. I wondered too what Jay made of his experience in this

family and how we might make sense of this young mother's complex need to be loved and what experiences she had that led her to choose men who treated her and her child so cruelly.

Now reflecting on this case, many years later, I wonder what stopped me from further exploring the protective concerns that I had about Jay's safety in the care of his mother or from thinking more clearly and courageously about the limits to this young mother's capacity to provide Jay with a good-enough emotional environment in which to grow and develop. Was I seduced by this mother's seeming eagerness for help, and so rendered unable to think the terrible thought that Charlene really might not be able to find in herself a sustained and genuine longing for Jay to be happy? Maybe Jay's delayed and stunted development might be meeting a need in her, and maybe, in turn, Jay's distorted behaviour had become his most potent and effective means of engaging his mother and so, in this way, it came to serve him too?

While Charlene was talking about the events of the past year, from time to time I spoke to Jay, commenting on the conversation that I was having with his mother. Jay remained aloof, but he seemed to listen closely. On the one occasion he reached out toward a toy, his mother remarked, "Jay doesn't play; he is not interested in toys." He soon let the toy drop. Even in a softer space with Jay, Charlene was unrelenting in her negative attributions of Jay and his behavior. It was painful to witness and to be with. I felt a deadening within myself and again wondered if this gave some clue to Jay's experience.

Another colleague, Vicki, an experienced senior clinician, was invited to meet with Charlene to ask her more about her losses and to explore her hopes for the future. Whilst Vicki was talking with Charlene, Jay and I shared some time in the room where we had met previously with his mother.

After a brief reflective discussion with Vicki, we offered to work with Charlene and Jay, both individually and together. In our infant-parent program we often worked in this way. Our experience was that the joint work, the child-parent therapy, was

often enhanced when both parent and child had a space in which to have a therapist's undivided attention before coming together for the joint relationship work. Many of the mothers we saw were overburdened and needy; almost all of them would have benefited from individual psychotherapy. Most of these women, however, were not ready to consider such a referral, and services for them were limited. What we offered was a space in which the therapist supported the mother to think about her child(ren).

Although the therapeutic plans were discussed with Charlene and she appeared to accept them, we failed to appreciate how fervently she continued to hold on to the idea that Jay had autism or to understand why this was so important to her. Her goal of ultimately receiving this diagnosis for him was at odds with the one we had identified for him and thought we were working toward together.

One week, Charlene arrived excited to share with us her pride in Jay. They had been invited to join in celebration for an uncle's birthday. Previously such occasions had been "a nightmare" for Charlene—Jay usually screamed and generally created havoc. On this occasion, all had gone well. Many people had congratulated Charlene on the "marvelous job" she was doing; Jay had been "great." Charlene had enjoyed him, and it seemed they had enjoyed the outing together. Vicki and I were delighted, and hoped that this was the promise of more harmonious family music to follow.

However, it did not last. Except for brief glimpses of the possibility of something being different, for the most part, Charlene took no pleasure from Jay or in his increasing vitality. She believed that he liked seeing me only because I "let him do what he wanted." It was not the case that I let him do whatever he wanted, though I tried to let him know it was all right to want whatever he wanted. The limits of the therapy room were very clear, and Jay knew them and accepted them. I do not think I was overindulgent of Jay, but his mother certainly did.

After 8 months of working together regularly, Charlene telephoned Vicki

to announce that she and Jay would not be coming back. Finally Jay would receive some "proper help," as he had been diagnosed with autism. I was flabbergasted, as was the rest of the team. Vicki admitted later she had an inkling "Charlene was up to something." She knew that Charlene had been seeing a psychologist who "was very helpful" to her because, she said, he knew she was "the mother and must be in charge." Charlene's sense of not being taken seriously by me was perhaps echoed in her rubbishing the work Jay and I were doing together by bringing it to an abrupt and premature end. She said they would not be coming back. It was as though she could not value any of the work we had shared.

Over the ensuing weeks, Vicki and I attempted to engage Charlene. We invited her and Jay to at least say good-bye. We were concerned about what sense Jay would make of never seeing us again; another abrupt and traumatic ending. In a telephone conversation with Vicki, Charlene said as it was some weeks since Jay had seen us, he had probably already forgotten who we were. What we had offered had been pushed aside, discarded, and reviled. This felt like the repetition of a destructive pattern we had not thought about clearly or fully enough in our work with Charlene and Jay.

Finally, brokenhearted, we had to concede we had been sacked and there would be no opportunity for reparation. Charlene had demonstrated a remarkable capacity to engage service providers and to split them into good or bad, helpful or unhelpful, supporting her or undermining her. Yet we failed to really see and think about the split that had widened in our team. The pediatrician who first made the referral to mental health services stated her concern that Jay's frequent presentation to health services was communicating something important that needed to be thought about. She was right. Despite our best intentions, we missed some very important opportunities to do this thinking, and so failed Jay and his mother.

## Reference

Winnicott, D. W. (1980). The theory of the parent-infant relationship. In D. W. Winnicott, *The maturational process and the facilitating environment* (pp. 37–55). London: Karnac. (Original work published 1960).

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