

# VII

## Ghosts in the Nursery: A Psychoanalytic Approach to the Problems of Impaired Infant-Mother Relationships

---

SELMA FRAIBERG  
EDNA ADELSON  
VIVIAN SHAPIRO

IN EVERY NURSERY there are ghosts. They are the visitors from the unremembered past of the parents, the uninvited guests at the christening. Under favorable circumstances, these unfriendly and unbidden spirits are banished from the nursery and return to their subterranean dwelling place. The baby makes his own imperative claim upon parental love and, in strict analogy with the fairy tales, the bonds of love protect the child and his parents against the intruders, the malevolent ghosts.

This is not to say that ghosts cannot invent mischief from their burial places. Even among families where the love bonds are stable and strong, the intruders from the parental past may break through the magic circle in an unguarded moment, and a parent and his child may

find themselves reenacting a moment or a scene from another time with another set of characters. Such events are unremarkable in the family theater, and neither the child nor his parents nor their bond is necessarily imperiled by a brief intrusion. It is not usually necessary for the parents to call upon us for clinical services.

In still other families there may be more troublesome events in the nursery caused by intruders from the past. There are, it appears, a number of transient ghosts who take up residence in the nursery on a selective basis. They appear to do their mischief according to a historical or topical agenda, specializing in such areas as feeding, sleep, toilet training or discipline, depending upon the vulnerabilities of the parental past. Under these circumstances, even when the bonds between parents and child are strong, the parents may feel helpless before the invasion and may seek professional guidance. In our own work, we have found that these parents will form a strong alliance with us to banish the intruders from the nursery. It is not difficult to find the educational or therapeutic means for dealing with the transient invaders.

But how shall we explain another group of families who appear to be possessed by their ghosts? The intruders from the past have taken up residence in the nursery, claiming tradition and rights of ownership. They have been present at the christening for two or more generations. While no one has issued an invitation, the ghosts take up residence and conduct the rehearsal of the family tragedy from a tattered script.

In our infant mental health program we have seen many of these families and their babies. The baby is already in peril by the time we meet him, showing the early signs of emotional starvation, or grave symptoms, or developmental impairment. In each of these cases the baby has become a silent actor in a family tragedy. The baby in these families is burdened by the oppressive past of his parents from the moment he enters the world. The parent, it seems, is condemned to repeat the tragedy of his own childhood with his own baby in terrible and exacting detail.

These parents may not come to us for professional guidance. Ghosts who have established their residence privileges for three or more generations may not, in fact, be identified as representatives of the parental past. There may be no readiness on the part of the parents to form an alliance with us to protect the baby. More likely it is we, and not the ghosts, who will appear as the intruders.

Those of us who have a professional interest in ghosts in the nursery do not yet understand the complexities and the paradoxes in the ghost story. What is it that determines whether the conflicted past of the parent will be repeated with his child? Is morbidity in the parental history the prime determinant? This strikes us as too simple. Certainly we all

know families in which a parental history of tragedy, cruelty, and sorrow have *not* been inflicted upon the children. The ghosts do not flood the nursery or erode the love bonds.

Then, too, we must reflect that if history predicted with fidelity, the human family itself would long ago have been drowned in its own oppressive past. The race improves. And this may be because the largest number of men and women who have known suffering find renewal and the healing of childhood pain in the experience of bringing a child into the world. In the simplest terms—we have heard it often from parents—the parent says, “I want something better for my child than I have had.” And he brings something better to his child. We have all known young parents who have suffered poverty, brutality, death, desertion, and sometimes the full gamut of childhood horrors, who do not inflict their pain upon their children. History is not destiny, then, and whether parenthood becomes flooded with griefs and injuries or whether it becomes a time of renewal cannot be predicted from the narrative of the parental past. There must be other factors in the psychological experience of that past which determine repetition in the present.

In therapeutic work with families on behalf of their babies we are all the beneficiaries of Freud’s discoveries before the dawn of this century. The ghosts, we know, represent the repetition of the past in the present. We are also the beneficiaries of the method Freud developed for recovering the events of the past and undoing the morbid effects of the past in the present. The babies themselves, who are often afflicted by the diseases of the parental past, have been the last to be the beneficiaries of the great discoveries of psychoanalysis and developmental psychology. These patients, who cannot talk, have had to await articulate spokesmen.

During the past three decades a number of psychoanalysts and developmental psychologists have been speaking for the babies. What the babies have been telling us is sobering news, indeed. This story you already know, and I will not attempt to summarize the vast literature that has emerged from our studies of infancy.

In our own work at the Child Development Project we have become well acquainted with the ghosts in the nursery. The brief intruders, which we have described, or the unwelcome ghosts who take up temporary residence, do not present extraordinary problems to the clinician. The parents themselves become our allies in banishing the ghosts. It is the third group, the ghosts who invade the nursery and take up residence, who present the gravest therapeutic problems for us.

How is it that the ghosts of the parental past can invade the nursery with such insistency and ownership, claiming their rights above the baby’s own rights? This question is at the center of our work. The an-

swers are emerging for us and in the closing section of this chapter we will return to the question and offer a hypothesis derived from clinical experience.

In this chapter we will describe our clinical study and our treatment through two of the many imperiled babies who have come to us. As our work progressed, our families and their babies opened doors to us which illuminated the past and the present. Our psychoanalytic knowledge opened pathways into understanding the repetition of the past in the present. The methods of treatment we developed brought together psychoanalysis, developmental psychology, and social work in ways that will be illustrated. The rewards for the babies, for the families, and for us have been very large.

In this collaborative work, Edna Adelson, staff psychologist, was the therapist for Jane and her family, Vivian Shapiro, staff social worker, was therapist for Greg and his family, and Selma Fraiberg served as case supervisor and psychoanalytic consultant.

### Jane

Jane, who came to us at 5½ months, was the first baby referred to our new infant mental health project. Her mother, Mrs. March, had appeared at an adoption agency some weeks earlier. She wanted to surrender her baby for adoption, but adoption plans could not proceed because Mr. March would not give his consent. Jane’s mother was described as “a rejecting mother.”

Now, of course nobody loves a rejecting mother, in our community or any other, and Jane and her family might at this point have disappeared into the anonymity of a metropolitan community, perhaps to surface once again when tragedy struck. But chance brought the family to one of the psychiatric clinics of our university. The psychiatric evaluation of Mrs. March revealed a severe depression, an attempted suicide through aspirin, a woman so tormented that she could barely go about the ordinary tasks of living. The “rejecting mother” was now seen as a depressed mother. Psychiatric treatment was recommended at a clinical staffing. And then one of the clinical team members said, “But what about the baby?” Our new project had been announced and scheduled for opening the following day. There was a phone call to us, and we agreed to provide immediate evaluation of the baby and to consider treatment.

### EARLY OBSERVATIONS

From the time Jane was first seen by us we had reason for grave concern. At 5½ months she bore all the stigmata of the child who has spent the greater part of her life in a crib with little more than obligatory care. She was adequately nourished and physically cared for, but the back of her head was bald. She showed little interest in her surround; she was listless, too quiet. She seemed to have only a tenuous connection with her mother. She rarely smiled. She did not spontaneously approach her mother through eye contact or gestures of reach. There were few spontaneous vocalizations. In moments of discomfort or anxiety she did not turn to her mother. In our developmental testing she failed nearly all the personal-social items on the Bayley scale. The test could not be completed. Jane was badly frightened by the unexpected sound of the test bell. After only a few more items her threshold of tolerance was shattered, and she collapsed into prolonged screaming.

The mother herself seemed locked in some private terror, remote, removed, yet giving us rare glimpses of a capacity for caring. For weeks we held onto one tiny vignette captured on videotape, in which the baby made an awkward reach for her mother and the mother's hand spontaneously reached toward the baby. The hands never met each other, but the gesture symbolized for the therapists a reaching out toward each other, and we clung to this symbolic hope.

There is a moment at the beginning of every case when something is revealed that speaks for the essence of the conflict. This moment appeared in the second session of the work when Mrs. Adelson invited Jane and her mother to our office. By chance it was a moment captured on videotape, because we were taping the developmental testing session as we customarily do. Jane and her mother, Mrs. Adelson, and Mrs. Evelyn Atreya, as tester, were present.

Jane begins to cry. It is a hoarse, eerie cry in a baby. Mrs. Atreya continues the testing. On tape we see the baby in her mother's arms screaming hopelessly; she does not turn to her mother for comfort. The mother looks distant, self-absorbed. She makes an absent gesture to comfort the baby, then gives up. She looks away. The screaming continues for five dreadful minutes on tape. In the background we hear Mrs. Adelson's voice, gently encouraging the mother: "What do you do to comfort Jane when she cries like this?" Mrs. March murmurs something inaudible. Mrs. Adelson and Mrs. Atreya are struggling with their own feelings. They are restraining their own wishes to pick up the baby and hold her, to murmur comforting things to her. If they should yield to their own wishes, they would do the one thing they feel must not be done. For Mrs. March would then see that another

woman could comfort the baby, and she would be confirmed in her own conviction that she was a bad mother. It is a dreadful five minutes for the baby, the mother, and the two clinicians. Mrs. Adelson maintains composure, speaks sympathetically to Mrs. March. Finally, the visit comes to an end when Mrs. Adelson suggests that the baby is fatigued and probably would welcome her own home and her crib; and mother and baby are helped to close the visit with plans for a third visit very soon.

As we watched this tape later in a staff session, we said to each other incredulously, "It's as if this mother doesn't hear her baby's cries!" This led us to the key diagnostic question, "Why doesn't this mother hear her baby's cries?"

### THE MOTHER'S STORY

Mrs. March was herself an abandoned child. Her mother suffered a postpartum psychosis shortly after the birth of Mrs. March. In an attempted suicide, she had injured herself and was horribly mutilated for life. She had then spent nearly all of the rest of her life in a hospital and was barely known to her children. For five years Mrs. March was cared for by an aunt. When the aunt could no longer care for her she was shifted to the house of the maternal grandmother, where she received grudging care from the burdened, impoverished old woman. Mrs. March's father was in and out of the family picture. We did not hear much about him until later in the treatment.

It was a story of bleak rural poverty, sinister family secrets, psychosis, crime, a tradition of promiscuity in the women, of filth and disorder in the home, and of police and protective agencies in the background making futile uplifting gestures. Mrs. March was the cast-out child of a cast-out family.

In late adolescence, Mrs. March met and married her husband, who came from poverty and family disorder not unlike her own. But he wanted something better for himself than his family had had. He became the first member of his family to fight his way out of the cycle of futility, to find steady work, to establish a decent home. When these two neglected and solitary young people found each other, there was mutual agreement that they wanted something better than what they had known. But now, after several years of effort, the downward spiral had begun.

There was a very high likelihood that Jane was not her father's child. Mrs. March had had a brief affair with another man. Her guilt over the affair, her doubts about Jane's paternity, became an obsessive theme in her story. In a kind of litany of griefs that we were to hear over and

over again, there was one theme: "People stared at Jane," she thought. "They stared at her and knew that her father was not her father. They knew that her mother had ruined her life."

Mr. March, who began to appear to us as the stronger parent, was not obsessed with Jane's paternity. He was convinced that he was Jane's father. And anyway, he loved Jane and he wanted her. His wife's obsession with paternity brought about shouting quarrels in the home. "Forget it!" said Mr. March. "Stop talking about it! And take care of Jane!" In the families of both mother and father illegitimacy carried no stigma. In the case of Mrs. March's clan, the promiscuity of their women over at least three or four generations cast doubt over the paternity of many of the children. Why was Mrs. March obsessed? Why the sense of tormenting sin? This pervasive, consuming sense of sin we thought belonged to childhood, to buried sins, quite possibly crimes of the imagination. On several occasions in reading the clinical reports, we had the strong impression that Jane was the sinful child of an incestuous fantasy. But if we were right, we thought to ourselves, how could we possibly reach this in our once-a-week psychotherapy?

#### TREATMENT: THE EMERGENCY PHASE

How shall we begin? We should remember that Jane and Mrs. March were our first patients. We did not have treatment models available to us. In fact, it was our task in this first infant mental health project to develop methods in the course of the work. It made sense, of course, to begin with a familiar model, in which our resident in psychiatry, Dr. Zinn, worked with the mother in weekly or twice-weekly psychotherapy, and the psychologist, Mrs. Adelson, provided support and developmental guidance on behalf of the baby through home visits. But within the first sessions, we saw that Mrs. March was taking flight from Dr. Zinn and psychiatric treatment. The situation in which she was alone with a man brought forth a phobic dread, and she was reduced to nearly inarticulate hours or to speaking of trivial concerns. All efforts to reach Mrs. March, or to touch upon her anxieties or discomfort in this relationship, led to an impasse. One theme was uttered over and over again. She did not trust men. But also, we caught glimpses in her oblique communications of a terrible secret that she would never reveal to anyone. She broke appointments more frequently than she kept them. With much difficulty, Dr. Zinn sustained a relationship with her. It was nearly a year before we finally heard the secret and understood the phobic dread that led to this formidable resistance.

There are no generalizations to be drawn from this experience. We have been asked sometimes if women therapists are more advantaged in working with mothers who have suffered severe maternal depriva-

tion themselves. Our answer, after nearly eight years of work, is, "Not necessarily; sometimes not at all." We have examples in our work in which the male therapist was specially advantaged in working with mothers. We tend to assign cases without overconcern about the sex of the therapist. Mrs. March must be regarded as an exceptional case.

But now we were faced with a therapeutic dilemma. Mrs. Adelson's work was to center in the infant-mother relationship through home visits. Mrs. March needed her own therapist, Dr. Zinn, but a morbid dread of men, aroused in the transference, prevented her from using the psychiatric help available to her. With much time and patient work in the psychiatric treatment, we would hope to uncover the secret that reduced her to silence and flight in the transference to Dr. Zinn.

But the baby was in great peril. And the baby could not wait for the resolution of the mother's neurosis.

Mrs. Adelson, we soon saw, did not arouse the same morbid anxieties in Mrs. March, but her role as the baby-mother therapist, the home-based psychologist, did not lend itself easily to uncovering the conflictual elements in the mother's relationship to the child and the treatment of the mother's depression.

Since we had no alternative, we decided we would use the home visits for our emergency treatment.

What emerged, then, was a form of "psychotherapy in the kitchen," so to speak, which will strike you as both familiar in its methods and unfamiliar in its setting. The method, a variant of psychoanalytic psychotherapy, made use of transference, the repetition of the past in the present, and interpretation. Equally important, the method included continuous developmental observations of the baby and a tactful, non-didactic education of the mother in the recognition of her baby's needs and her signals.

The setting was the family kitchen or the living room. The patient who couldn't talk was always present at the interviews—if she wasn't napping. The patient who could talk went about her domestic tasks or diapered or fed the baby. The therapist's eyes and ears were attuned to both the nonverbal communications of the baby and the substance of the mother's verbal and nonverbal communications. Everything that transpired between mother and baby was in the purview of the therapist and in the center of the therapy. The dialogue between the mother and the therapist centered upon present concerns and moved back and forth between the past and the present, between this mother and child and another child and her family in the mother's past. The method proved itself and led us, in later cases, to explore the possibilities of the single therapist in the home-based treatment.

We shall now try to summarize the treatment of Jane and her mother and examine the methods that were employed.

The therapist was giving Mrs. March permission to feel and to remember feelings. It may have been the first time in Mrs. March's life that someone had given her this permission. And gradually, as we should expect—but within only a few sessions—grief, tears, and unspeakable anguish for herself as a castoff child began to emerge. It was finally a relief to be able to cry, a comfort to feel the understanding of her therapist. And now, with each session, Mrs. Adelson witnessed something almost unbelievable happening between mother and baby.

You remember that the baby was nearly always in the room in the midst of this living room-kitchen therapy of ours. If Jane demanded attention, the mother would rise in the midst of the interview to diaper her or get her a bottle. More often, the baby was ignored if she did not demand attention. But now, as Mrs. March began to take the permission to remember her feelings, to cry, and to feel the comfort and sympathy of Mrs. Adelson, we saw her make approaches to her baby in the midst of her own outpourings. She would pick up Jane and hold her, at first distant and self-absorbed, but holding her. And then one day, still within the first month of treatment, Mrs. March, in the midst of an outpouring of grief, picked up Jane, held her very close, and crooned to her in a heartbroken voice. And then it happened again, and several times in the next sessions. An outpouring of old griefs and a gathering of the baby into her arms. The ghosts in the baby's nursery were beginning to leave.

These were more than transitory gestures toward rapprochement with the baby. From all evidence to Mrs. Adelson's observing eyes, mother and baby were beginning to find each other. And now that they were coming into touch with each other, Mrs. Adelson did everything within her capacity as therapist and developmental psychologist to promote the emerging attachment. When Jane rewarded her mother with a beautiful and special smile, Mrs. Adelson commented on it and observed that she, Mrs. Adelson, did not get such a smile, which was just the way it should be. That smile belonged to her mother. When a crying Jane began to seek her mother's comfort and found relief in her mother's arms, Mrs. Adelson spoke for Jane. "It feels so good when mother knows what you want." And Mrs. March herself smiled shyly, but with pride.

These sessions with mother and baby soon took on their own rhythm. Mr. March was often present for a short time before leaving for work. (Special sessions for father were also worked out on evenings and Saturdays.) The sessions typically began with Jane in the room and Jane as the topic of discussion. In a natural, informal, nondidactic way, Mrs. Adelson would comment with pleasure on Jane's development and weave into her comments useful information about the needs of babies at 6 months or 7 months and how Jane was learning about her

In the early hours of treatment, Mrs. March's own story emerged haltingly, narrated in a distant, sad voice. It was the story we sketched earlier. As the mother told her story, Jane, our second patient, sat propped on the couch or lay stretched out on a blanket, and the sad and distant face of the mother was mirrored in the sad and distant face of the baby. It was a room crowded with ghosts. The mother's story of abandonment and neglect was now being psychologically reenacted with her own baby.

The problem, in the emergency phase of the treatment, was to get the ghosts out of the baby's nursery. To do this we would need to help the mother to see the repetition of the past in the present, which we all know how to do in an office that is properly furnished with a desk and a chair or a couch, but which we had not yet learned to do in a family living room or a kitchen. The therapeutic principles would need to be the same, we decided. But in this emergency phase of the treatment, on behalf of a baby, we would have to find a path into the conflictual elements of the mother's neurosis which had direct bearing upon her capacity to mother. The baby would need to be at the center of treatment for the emergency period.

We began, as we said, with the question to ourselves: "Why can't this mother hear her baby's cries?"

The answer to the clinical question is already suggested in the mother's story. This is a mother whose own cries have not been heard. There were, we thought, two crying children in the living room. The mother's distant voice, her remoteness and remove we saw as defenses against grief and intolerable pain. Her terrible story had been first given factually, without visible suffering, without tears. All that was visible was the sad, empty, hopeless look upon her face. She had closed the door on the weeping child within herself as surely as she had closed the door upon her crying baby.

This led to our first clinical hypothesis: *When this mother's own cries are heard, she will hear her child's cries.*

Mrs. Adelson's work, then, centered upon the development of a treatment relationship in which trust could be given by a young woman who had not known trust, and in which trust could lead to the revelation of the old feelings which closed her off from her child. As Mrs. March's story moved back and forth between her baby, "I can't love Jane," and her own childhood, which can be summarized, "Nobody wanted me," the therapist opened up pathways of feeling. Mrs. Adelson listened and put into words the feelings of Mrs. March as a child. "How hard this must have been. . . . This must have hurt deeply. . . . Of course, you needed your mother. There was no one to turn to. . . . Yes. Sometimes grownups don't understand what all this means to a child. You must have needed to cry. . . . There was no one to hear you."

internal conflicts, and there were a number of problems in mother-child relationships which emerged during that year; but Jane was out of danger, and even the baby conflicts of the second year of life were not extraordinary or morbid. Once the bond had been formed, nearly everything else could find solutions.

#### OTHER CONFLICTUAL AREAS

We shall try to summarize the following months of treatment. Jane remained the focus of our work. And following the pattern already established, the therapeutic work moved freely between the baby and her developmental needs and problems and the mother's conflicted past.

One poignant example comes to mind. Mrs. March, in spite of new-found pleasure and pride in motherhood, could still make casual and unfeeling plans for babysitting. The meaning of separation and temporary loss to a 1-year-old child did not register with Mrs. March. When the mother took part-time work at one point (and the family poverty gave some justification for additional income), Mrs. March made hasty and ill-thought-out sitting arrangements for Jane and then was surprised, as was Mr. March, to find that Jane was sometimes "cranky" and "spoiled" and "mean."

Mrs. Adelson tried in a number of tactful ways to help the Marches think about the meaning to Jane of her love for mother and her temporary loss of mother during the day. She met a blank wall. Both parents had known shifting and casual relationships with parents and parent-substitutes from their earliest years. The meaning of separation and loss was buried in memory. Their family style of coping with separation, desertion, or death was "Forget about it. You get used to it." Mrs. March could not remember grief or pain at the loss of important persons.

Somehow once again we were going to have to find the affective links between loss and denial of loss, for the baby in the present, and loss in the mother's past.

The moment came one morning when Mrs. Adelson arrived to find the family in disorder: Jane crying at the approach of a now-familiar visitor, parents angry at a baby who was being "just plain stubborn." Thoughtful inquiries from Mrs. Adelson brought the new information that Jane had just lost one sitter and started with another. Mrs. Adelson wondered out loud what this might mean to Jane. Yesterday she had been left, unexpectedly, in a totally new place with a strange woman. She felt alone and frightened without her mother, and did not know what was going to happen. No one could explain things to her; she was only a baby, with no words to express her serious problem. Somehow,

world and how her mother and father were leading her into these discoveries. Together the parents and Mrs. Adelson would watch Jane experiment with a new toy or a new posture, and, with close watching, could see how she was finding solutions and moving steadily forward. The delights of baby-watching, which Mrs. Adelson knew, were shared with Mr. and Mrs. March, and, to our great pleasure, both parents began to share these delights and to bring in their own observations of Jane and of her new accomplishments.

During the same session, after Mr. March had left for work, the talk would move at one point or another back to Mrs. March herself, to her present griefs and her childhood griefs. More and more frequently now, Mrs. Adelson could help Mrs. March see the connections between the past and the present and show her how "without realizing it," she had brought her sufferings of the past into her relationship with her own baby.

Within four months Jane became a healthy, more responsive, often joyful baby. At our ten-month testing, objective assessment showed her to be age-appropriate in her focused attachment to her mother, in her preferential smiling and vocalization to mother and father, in her seeking of her mother for comfort and safety. The Bayley developmental testing showed uneven but impressive progress. Jane was two months advanced on social interaction items and at age level for fine motor performance for her corrected age. Lags of from one to two months on vocalization and gross motor items placed her below her corrected age, but still within the normal range.

Mrs. March had become a responsive mother and a proud mother. Yet our cautious rating of the mother's own psychological state remained: "depressed." It was true that Mrs. March was progressing, and we saw many signs that the depression was no longer pervasive and constricting, but depression was still there, and, we thought, still ominous. Much work remained.

What we had achieved, then, in our first four months' work was not yet a cure of the mother's illness, but a form of control of the disease, in which the pathology which had spread to embrace the baby was now largely withdrawn from the child; the conflictual elements of the mother's neurosis were now identified by the mother as well as ourselves as "belonging to the past" and "not belonging to Jane." The bonds between mother and baby had emerged. And the baby herself was insuring those bonds. For every gesture of love from her mother, she gave generous rewards of love. Mrs. March, we thought, may have felt cherished by someone for the first time in her life.

All this constitutes what we would call "the emergency phase of the treatment." Now, in retrospect, we can tell you that it took a full year beyond this point to bring some resolution to Mrs. March's very severe

we would have to find a way to understand and to help her with her fears and worries.

Mr. March, on his way to work, stopped long enough to listen attentively. Mrs. March was listening too, and before her husband left, she asked him to try to get home earlier today so that Jane would not be too long at the sitter's.

There followed a moving session in which the mother cried, and the baby cried, and something very important was put into words. In a circular and tentative way, Mrs. March began to talk about Aunt Ruth, with whom she had lived during her first five years. There had not been a letter from Aunt Ruth for some months. She thought Aunt Ruth was angry at her. She switched to her mother-in-law, to thoughts of her coldness and rejection of Mrs. March. Then came complaints about the sitters, with the theme that one sitter was angry because Jane cried when her mother left. The theme was "rejection" and "loss," and Mrs. March was searching for it everywhere in the contemporary scene. She cried throughout, but somehow even with Mrs. Adelson's gentle hints, she could not put all this together.

Then at one point Mrs. March left the room, still in tears, and returned with a family photograph album. She identified the pictures for Mrs. Adelson. Mother, father, Aunt Ruth, Aunt Ruth's son who had been killed in the war. Sorrow for Aunt Ruth. Nobody in the family would let her grieve for her son. "Forget about it" is what they said. She spoke about her father's death and her grandfather's death in the recent past.

Many losses, many shocks, just before Jane's birth, she was saying. And the family always said, "Forget about it." And then Mrs. Adelson, listening sympathetically, reminded her that there had been many other losses, many other shocks for Mrs. March long ago in her infancy and childhood. The loss of her mother, which she could not remember, and the loss of Aunt Ruth when she was 5 years old. Mrs. Adelson asked how Mrs. March had felt then, when she was too young to understand what was happening. Looking at Jane, sitting on her mother's lap, Mrs. Adelson said, "I wonder if we could understand how Jane would feel right now if she suddenly found herself in a new house, not just for an hour or two with a sitter, but permanently, never to see her mother or father again. Jane wouldn't have any way to understand this; it would leave her very worried, very upset. I wonder what it was like for you when you were a little girl."

Mrs. March listened, deep in thought. A moment later she said, in an angry and assertive voice, "You can't just replace one person with another. . . . You can't stop loving them and thinking about them. You can't just replace somebody." She was speaking of herself now. Mrs.

Adelson agreed, and then gently brought the insight back on behalf of Jane.

This was the beginning of new insights for Mrs. March. As she was helped to reexperience loss, grief, and feelings of rejection in childhood, she could no longer inflict this pain upon her own child. "I would never want my baby to feel that," she said with profound feeling. She was beginning to understand loss and grief. With Mrs. Adelson's help, she now began to work out a stable sitter plan for Jane, with full understanding of the meaning to her child. Jane's anxieties began to diminish, and she settled into her new regime.

Finally, too, we learned the dread secret which had invaded the transference to Dr. Zinn and caused her to take flight from psychiatric treatment. The morbid fear of being alone in the same room with the doctor, the obsessive sense of sin which had attached itself to Jane's doubtful paternity, had given us the strong clinical impression that Jane was "an incestuous baby," conceived long ago in childhood fantasy, made real through the illicit relationship with an out-of-wedlock lover. By this we meant nothing more than "an incestuous fantasy," of course. We were not prepared for the story that finally emerged. With great shame and suffering, Mrs. March told Mrs. Adelson in the second year of treatment her childhood secrets. Her own father had exhibited himself to her when she was a child and had approached her and her grandmother in the bed they shared. Her grandmother had accused her of seducing her elderly grandfather. This Mrs. March denied. And her first intercourse at the age of 11 took place with her cousin, who stood in the relationship of brother to her, since they shared the same house in the early years of life. Incest was not fantasy for Mrs. March. And now we understood the obsessive sense of sin which had attached itself to Jane and her uncertain paternity.

#### JANE AT 2 YEARS OF AGE

During the second year of treatment, Mrs. Adelson continued as the therapist for Mrs. March. Dr. Zinn had completed his residency, and Mrs. March's transference to Mrs. Adelson favored continuity in the work with the mother. William Schafer, psychologist on our staff, became the guidance worker for Jane. (We no longer have separate therapists for parent and child, but in this first case we were still experimenting.)

It is of some considerable interest that in the initial meetings with Mr. Schafer, Mrs. March was again in mute terror as her morbid fear of "a man" was revived in transference. But this time Mrs. March had made large advances in her therapeutic work. The anxiety was handled

in transference by Mr. Schafer, and brought back to Mrs. Adelson where it could be placed within the context of the incestuous material that had emerged in treatment. The anxiety diminished, and Mrs. March was able to make a strong alliance with Mr. Schafer. The developmental guidance of the second year brought further strength and stability to the mother-child relationship, and we saw Jane continuing her developmental progress through her second year, even as her mother was working through very painful material in her own therapeutic work.

Were there residues in Jane's personality from the early months of neglect? As a 2-year-old, Jane was an attractive, busy little girl who presented no extraordinary problems in development. The only residue we could detect was a momentary stoppage of play at times when Mrs. March became temporarily uncomfortable, as in an unfamiliar social setting or when recalling particularly painful memories.

For the rest, Jane was a bright, vocal, sociable child. Her affectionate ties to her mother and father appeared to us as appropriate for her age. She was remarkably free from signs of withdrawal, self-absorption, or separation anxiety. In spontaneous doll play, we saw a strong positive identification with her mother and with acts of mothering. She was a solicitous mother to her dolls, feeding, dressing them with evident pleasure, murmuring comforting things to them. Bayley developmental testing showed continued progress. She had retained her age adequacy on social interaction and fine motor items. Gross motor development was now also at age level. Language, which had previously been a major area of concern, now showed only a slight delay of one month.

It was in doll play at 1:10:0 that Mr. Schafer first heard Jane speak a full sentence. Her doll was accidentally trapped behind a door with a spring catch, and Jane could not recover it. "I want my baby. I want my baby!" she called out in an imperative voice. It was a very good sentence for a 2-year-old. It was also a moving statement to all of us who knew Jane's story.

For us the story must end here. The family has moved on. Mr. March begins a new career with very good prospects in a new community that provides comfortable housing and a warm welcome. The external circumstances look promising. More important, the family has grown closer; abandonment is not a central concern. One of the most hopeful signs was Mrs. March's steady ability to handle the stress of the uncertainty that preceded the job choice. And as termination approached, she could openly acknowledge her sadness. Looking ahead, she expressed her wish for Jane: "I hope that she'll grow up to be happier than me. I hope that she will have a better marriage and children who she'll love." For herself, she asked that we remember her as "someone who had changed."

## Greg

Within the first weeks of our new program we were asked to make an urgent call and an assessment of Greg, then 3½ months old. His 16-year-old mother, Annie, refused to care for him. She avoided physical contact with the baby; she often forgot to buy milk for him, and she fed him Kool-Aid and Tang. She turned over the baby's care to her 19-year-old husband, Earl.

Annie's family had been known to social agencies in our community for three generations. Delinquency, promiscuity, child abuse, neglect, poverty, school failure, psychosis had brought every member of the family to our community clinics and courts. Annie Beyer at 16 now resented the third generation of mothers in her family who actually or psychologically abandoned their babies. Annie's mother had surrendered the care of her children to others. As did her mother. And it was, in fact, Greg's grandmother, Annie's mother, who called our agency for help. She said, "I don't want to see what happened to me and my babies happen to Annie and her baby."

Vivian Shapiro of our staff called for an appointment and made a home visit immediately. Mother, father, and Greg were present. Mrs. Shapiro was greeted by a cold and silently hostile adolescent mother, a sad, bewildered boy who was the father, and a solemn baby who never once in that hour looked at his mother. Greg was developmentally adequate for his age, Mrs. Shapiro estimated, and her impressions were later sustained by our developmental testing. This spoke for some minimum adequacy in care, and we had good reason to believe that it was Earl, the father, who was providing most of Greg's care. At nearly every point in the one-hour session when Greg required care, Annie summoned her husband or picked up the baby and gave him to his father. He settled comfortably with his father and, for father, there were smiles.

During most of this session, and for many others that followed, Annie sat slumped in a chair. She was obese, unkempt, and her face registered no emotion. It was a mask which Mrs. Shapiro was to see many times, but when Annie brought herself to speak, there was barely controlled rage in her voice.

She did not want our help. There was nothing wrong with her or her child. She accused her mother of a conspiracy against her and, in her mind, Mrs. Shapiro was part of the conspiracy. Winning Annie's trust



was to become our most arduous therapeutic task of those first weeks. To maintain the trust, after it was given, was equally difficult. It was a great advantage to Mrs. Shapiro, as it has been for all of us, to have come to this work with broad clinical experience with children and adolescents. An adolescent girl who defies her would-be helpers, who challenges, provokes, tests mercilessly, breaks appointments, disappears to another address, will not cause an experienced social worker to turn a hair. Mrs. Shapiro could wait to earn Annie's trust. But there was a baby in peril, and within only a few visits, we understood how great the peril was.

We began with the question to ourselves, "Why does Annie avoid touching and holding her baby?" To find the answers, we would need to know more about Annie than she was willing to give in those early hostile hours. And always there was Greg, whose own needs were imperative, and who could not wait for his teenage mother to make the therapeutic alliance, which is slow-paced in adolescence. It was surely not ignorance of the needs of babies that distanced Annie from her child. Doctors and public health nurses had given wise counsel before we ever met the Beyer family. She could not use the good advice.

#### AN ILLUMINATING HOUR

In the sixth home visit, something of the therapist's caring for Annie as a lonely and frightened child came through. Annie began to speak of herself. It made her angry, she said warily, when her husband, when people, thought she wasn't doing enough for her baby. She knew she was. Anyway, she said, she had never liked holding a baby very much . . . ever since she was a little girl. When she was little, she had had to take care of her younger sister. She would be given the baby and told to hold her. She much preferred leaving the baby on the couch.

And then, led on by tactful questions, she began to speak of her childhood. We heard about Annie, as a 9-year-old girl, responsible for the cleaning, cooking, and care of other siblings—after school hours. For any negligence in duties, there were beatings from her stepfather, Mr. Bragg.

Annie spoke of her childhood in a flat, dull voice, with only an edge of bitterness in it. She remembered everything, in chilling detail. And what Annie told the therapist was not a fantasy and was not distorted, since the story of Annie's family had been factually recorded by protective agencies and clinics throughout her community. There was the mother who periodically deserted her family. There was the father who died when Annie was 5 years old. And there was Mr. Bragg, the stepfather, alcoholic, probably psychotic. For trivial misdemeanors he dragged Annie off to the woodshed and beat her with a lath.

When Mrs. Shapiro spoke to the feelings of Annie as a child, of anger, fear, helplessness, Annie warded off these sympathetic overtures. She laughed cynically. She was tough. Her sister Millie and she got so they would just laugh at the old man when it was over.

In this session, in the midst of Annie's factual account of childhood horrors, Greg began a fretful cry, needing attention. Annie went to the bedroom and brought him back with her. For the first time in six visits Mrs. Shapiro saw Annie hold Greg closely cuddled in her arms.

This was the moment Mrs. Shapiro had been waiting for. It was the sign, perhaps, that if Annie could speak of her childhood sufferings, she could move protectively toward her baby.

The baby clutched his mother's hair as she bent over him. Annie, still half in the past and half in the present, said musingly, "Once my stepfather cut my hair to here," and pointed to her ears. "It was a punishment because I was bad." When Mrs. Shapiro said, "That must have been terrible for you!" Annie, for the first time, acknowledged feelings. "It was terrible. I cried for three days about it."

At this point, Annie began to talk to the baby. She told him he was smelly and needed to be changed. While Annie was changing him, Greg seemed to be looking for something to play with. There was a toy beside him on the couch. It was, of all things, a toy plastic hammer. Annie picked up the toy hammer and tapped it, gently, against the baby's head. Then she said, "I'm gonna beat you. I'm gonna beat you!" Her voice was teasing, but Mrs. Shapiro sensed the ominous intention in these words. And while still registering, as therapist, the revealed moment, Mrs. Shapiro heard Annie say to her baby, "When you grow up, I might kill you."

It was the close of the session. Mrs. Shapiro said those things that would quiet the turbulence in Annie, supporting the positive strivings toward motherhood, allying herself with those parts of the ego of this girl-mother that sought protection against the dangerous impulses.

But this, we knew, as we talked together in an emergency session back at the office, would not be enough to protect the baby from his mother. If Annie had to rely upon her therapist as an auxiliary ego, she would need to have her therapist in constant attendance.

#### AN EMERGENCY CLINICAL CONFERENCE

The question was, how could we help Annie and her baby? We now knew why Annie was afraid to be close to her baby. She was afraid of her own destructive feelings toward him. But we had read these signs from the breakthrough of unconscious impulses in the tease games with the baby. We could not interpret sadistic impulses which were not yet conscious to Annie herself. If we cooperated with the ego to main-

tain these sadistic impulses in repression, Annie would have to distance herself from her baby. And the baby was our patient too. Our most vulnerable patient.

We were attentive to small positive signs in this session. After talking about her childhood terrors, even though the affect was flat in the telling, Annie did pick up her baby and hold him close and cuddle him. And this was the first time we had seen closeness between mother and baby in six sessions. If Annie could remember and speak of her childhood suffering, could we open pathways which would free her baby from her own past and enable her to mother Greg? If Annie could be helped to examine her feelings toward the baby, if we could elicit the unspeakable thoughts, would Annie be able to reach out to her baby?

From the standpoint of an exercise in pure theory and method, we were probably on the right track in our thinking. The case considerations were derived from psychoanalytic experience. But this was not a psychoanalysis. As psychoanalytic consultant, Selma Fraiberg recalls that she suddenly found herself bereft of all the conditions and the protections against error which are built into the psychoanalytic situation.

First of all, the conditions of this therapy on behalf of a baby and his adolescent mother made it imperative to move quickly to protect the baby. Under all normal circumstances in therapy, we believe in cautious exploration: an assessment of the ego's capacity to deal with painful affects, an assessment of the defensive structure of the patient. Also, as experienced therapists with adolescents, we knew that to win the trust of this hostile girl might easily take months of work. And the baby was in immediate danger.

We were attentive to the defenses against painful affect which we saw in Annie. She remembered, factually, the experiences of childhood abuse. What she did not remember was her suffering. Would the liberation of affect in therapy increase the likelihood of acting out toward the baby or would it decrease the risks? After thorough discussion of alternatives, we decided, with much trepidation, that the chances of acting out toward the baby would be greater if the anxiety and rage were not elicited in treatment. Selma Fraiberg recalls: "Speaking for myself, I clung to the belief that it is the parent who cannot remember his childhood feelings of pain and anxiety who will need to inflict his pain upon his child. And then I thought: 'But what if I am wrong?'"

Then we would also be confronted with another therapeutic problem in this once-a-week psychotherapy. If we worked within the realm of buried affects, we could predict that the therapist who conjures up the ghosts will be endowed in transference with the fearsome attributes of the ghost. We would have to be prepared for the transference ghosts and meet them squarely every step of the way.

As we reviewed these conference notes one year later, we were satisfied that our treatment formulations had stood up well in the practical test. We now know, through the progress of our treatment, that the main lines of the work were well considered.

But now we shall have to take you with us on a detour from the treatment that turned out to be as important for the outcome as the psychotherapeutic plan.

Before any part of this treatment plan could be put into effect, Annie took flight from the therapist.

#### ANNIE LOCKS THE DOOR: A FLIGHT FROM TREATMENT

You remember that our emergency conference had followed the critical sixth session interview in which Annie began to speak of her childhood beatings. The seventh session was a home visit in which a number of Annie's relatives came to visit, and there was no opportunity to speak with Annie alone. In the eighth session, Mrs. Shapiro arranged to speak with both Annie and Earl about continuing visits and to invite them to raise questions with her about how we might best be able to help the Beyers. Earl said emphatically that he wanted Mrs. Shapiro to continue visiting them. He said that he felt Mrs. Shapiro was helping them to see things about Greg's development that they would never have been able to see themselves. Annie remained silent. Then, when Mrs. Shapiro inquired about Annie's wishes, Annie said, with some hesitation, that she would like Mrs. Shapiro to continue to come. She would like to be able to talk about the baby and about herself.

In this hour Annie herself picked up the narrative which had begun in the sixth session. She began, however, by speaking of her fears that Earl drives too fast, that he might have an accident. A child needed a father. Greg needed a father. This led her to speak of her own father, her natural father, with some affection. After her father died when Annie was 5 years old, nobody ever really cared for her. There had been several men in the household who lived with Annie's mother. There were six children, born to four different fathers. Millie was her mother's favorite. Annie said bitterly, "They didn't want me. I didn't want them. I didn't need anybody." She spoke again of Mr. Bragg and the beatings. At first she used to cry, but he wouldn't stop. Then later, she would laugh, because it didn't hurt any more. He beat her with a lath. He would beat her until the lath broke.

After her father died, Annie's mother disappeared. She went to work in another city, leaving the children with an old woman. To punish the children, the old woman locked them out of the house. She remembered one night when she and Millie were locked out in the freezing cold and huddled together. Her mother never seemed to know what

was going on. Even when she returned to her family, she went to work, and even when she wasn't working, she didn't seem to be around.

To all this Mrs. Shapiro listened with great sympathy. She spoke of a child's need for protection. How frightening to a child to have no one to protect her. How much Annie missed her mother and a mother's protection. Perhaps she would be a different kind of mother to Greg. Would she feel she had to protect him? "Of course," Annie replied.

And very gently, Mrs. Shapiro spoke of the deep unhappiness and loneliness in Annie's childhood, and how difficult it was to be a young mother who had missed so much in her own childhood. Together, Mrs. Shapiro and Annie would talk about these things in their future visits.

It was, Mrs. Shapiro felt, a good visit: clarification of the role of the therapist, an acknowledgment that Annie and Earl wanted help for themselves and for their baby. For Annie, the beginning of the permission to feel along with remembering. A permission that she was not yet ready to take. But this would come.

And then, following this visit, Annie refused to see Mrs. Shapiro. There were numerous broken appointments. Appointments would be made, but Annie would not be at home. Or Mrs. Shapiro would arrive, with all signs of activity in the house, and Annie would refuse to answer the door. Annie literally locked the door against Mrs. Shapiro.

It was no consolation during a period like this to understand the nature of transference resistance while the patient barricades the door against the therapist. It is far worse to know that there are two patients behind the door and that one of them is a baby.

As the memories of childhood terrors emerged in that last session, the original affects must have emerged—not in the treatment hour, but afterward—and the therapist became the representative of fears that could not be named. Annie did not remember or experience her anxiety during the brutal bearings by Mr. Bragg, but anxiety attached itself to the person of the therapist, and Annie took flight. Annie did not remember the terror of being locked out of the house by the woman who cared for her when her mother deserted the family, and to make sure that she would not remember, the ghosts and the ego conspired to lock Mrs. Shapiro out of the house. Annie did not remember the terror of abandonment by her mother, but she reenacted the experience in transference, creating the conditions under which the therapist might have to abandon her.

We were, ourselves, nearly helpless. But this is not to say that the psychoanalytic insight was without value. To understand all this gave us a measure of control in the countertransference. We were not going to abandon Annie and her baby. We understood the suffering behind

the provocative, tough, and insolent adolescent posture, and could respond to the anxiety and not the defense.

The only thing we lacked was a patient who could benefit from the insight. And there was the baby who was more imperiled than his mother.

During the two-month period in which Mrs. Shapiro was locked out of the house, reports from grandparents, visiting nurse, and others increased our alarm. Annie showed phobic symptoms. She was afraid to be alone in the house. And she was pregnant again. Greg looked neglected. He was suffering from recurrent upper respiratory illness and was not receiving medical care. The paternal grandparents were alarmed for Greg and reported to Mrs. Shapiro that Annie was playing rough games with Greg, swinging him from his ankles.

Our own alarm for Greg brought us to a painful decision. In our hospital and in our community we are ethically and legally bound to report cases of neglect and suspected or actual abuse to Protective Services. In a case where treatment alternatives are rejected by the family (as in Annie's case) the report is mandatory. The law is wise, but in the exercise of our legal responsibility we would bring still another tragedy to the Beyer family.

This was a critical moment, not only for the family but for Mrs. Shapiro and for our entire staff. There is no greater irony for the clinician than that in which he possesses the knowledge and the methods to prevent a tragedy and cannot bring this help to those who need it. Clinically speaking, the solution to the problem resided in the transference resistance. Exploration of the negative transference with Annie would prevent further acting out. We all know how to deal with transference ghosts in an office with a patient who gives even grudging cooperation with our method. How do we deal with the negative transference when the patient has locked herself in a house with her baby and their ghosts and will not answer the door?

The considerations for Greg were paramount now. Mrs. Shapiro wanted to prepare Annie and Earl for the painful alternative which lay before us, a referral to Protective Services. But Annie refused to answer the door when Mrs. Shapiro called.

As a sad alternative, Mrs. Shapiro prepared a letter which was sent to Annie and Earl and to both sets of grandparents. It was a letter which spoke for our concern and deep caring for both of the young parents and for their baby. It cited the many attempts we had made to reach the family with our help and our wish, still, to help this young family. If they felt we could not help them, we would need to seek help for them elsewhere, and we would request the help of Protective Services. A reply was requested within the week.

wardness was to diminish over time, and we were later to witness a growing pleasure in physical intimacy with her baby.)

In successive sessions, Annie took the permission to speak of her feelings. And the story of childhood privations, of brutality and neglect, began to emerge once again, as if the narrative begun two months ago could now be resumed. But this time Mrs. Shapiro knew what had caused Annie to take flight from treatment two months ago, and her own insight could be employed in a method which would prevent flight or acting out and would ultimately lead to resolution. It was not the telling of the tales which had caused Annie to take flight, but the unspoken affect which had been maintained in isolation from the memories. Annie, you remember, had described her stepfather's beatings in exact and chilling detail, but the affect was isolated. She laughed cynically throughout that early session. Somewhere between the factual reporting of beatings and neglect and the flight from Mrs. Shapiro, affect which had been maintained in partial repression had emerged, and anger, fear, simple terror sought an object, a name for itself, and the name was Mrs. Shapiro.

This time, with the start of treatment, properly speaking, Mrs. Shapiro elicited affect along with the telling and made it safe to remember. When the story of childhood horrors emerged now, Mrs. Shapiro offered her own commentary. "How frightening to a child. You were only a child then. There was no one to protect you. Every child has a right to be taken care of and protected." And Annie said, with bitterness, "The mother is supposed to protect the children. My mother didn't do that." There was a refrain in these early hours which appears in the record again and again. "I was hurt. I was hurt. Everyone in my family is violent." And then another refrain. "I don't want to hurt anybody. I don't want to hurt anybody." Mrs. Shapiro, listening attentively, said, "I know you don't want to hurt anybody. I know how much you have suffered and how much it hurt. As we talk about your feelings, even though it is painful to remember, it will be possible to find ways to come to terms with some of these things and to be the kind of mother you want to be."

Annie, we saw, got both sides of the message. Mrs. Shapiro was on the side of the ego which defended against the unconscious wish to hurt and to repeat the hurts with her own child. At the same time, Mrs. Shapiro was saying, in effect, "It will be safe with me to speak of the frightening memories and thoughts, and when you speak of them you will no longer need to be afraid of them; you will have another kind of control over them."

Mrs. Shapiro also anticipated with Annie the possibility of negative transference feelings that might arise during sessions where painful memories would be revived. Mrs. Shapiro said to Annie, "It may be

We learned within a few days of the impact of this letter on Annie and Earl and the grandparents. Annie cried for the entire weekend. She was angry at Mrs. Shapiro. She was frightened. But on Monday she called Mrs. Shapiro. Her voice was exhausted, but she managed to say that everything in Mrs. Shapiro's letter was true. She would see Mrs. Shapiro.

#### EXTENDED TREATMENT

This was the beginning of a new relationship between Annie and Earl and Mrs. Shapiro. Step by step, Mrs. Shapiro dealt with Annie's distrust, her anger toward Mrs. Shapiro and all "helping people," and clarified her own role as a helping person. Mrs. Shapiro was on the side of Annie and Earl and Greg and wanted to do everything possible to help them—to find the good things they wanted and deserved in life, and to give Greg all the things he needed to become a healthy and happy child.

For Annie, the relationship with Mrs. Shapiro became a new experience, unlike anything she had known. Mrs. Shapiro began, of course, by dealing openly with the anger which Annie had felt toward her, and she made it safe for Annie to put anger into words. In a family pattern where anger and murderous rage were fused, Annie had only been able to deal with anger through fight or identification with the aggressor. In the family theater, anger toward the mother and desertion by the mother were interlocking themes. But Annie learned that she could feel anger and acknowledge anger toward her therapist, and her therapist would not retaliate and would not abandon her.

It was safe to experience anger in transference to the therapist, and within this protected relationship the pathways of anger led back to childhood griefs and terrors. It was not an easy path for Annie. Yes, she acknowledged in a session soon after Mrs. Shapiro began visiting again, yes, she had felt bad about the therapist coming to see her. Yes, she resented her. "But what's the use of talking? I always kept things to myself. I want to forget. I don't want to think."

Mrs. Shapiro, with full sympathy for Annie's suffering and the need to forget, discussed with Annie how trying to forget did not get rid of the feelings or the memories. Annie would only be able to make peace with her feelings by talking about them to Mrs. Shapiro. Together, through talking, the therapist would be able to help Annie feel better.

Annie did not reply in words. At this point in the session she picked up Greg and held him very close, rocking him in her arms. But the tension within her was transmitted to Greg; she was holding him too tightly and the baby began to protest. Yet we had seen Annie reach spontaneously for her baby, and this was a favorable sign. (Her awk-

that in talking about the past, you will feel angry toward me, without knowing why. Perhaps you could tell me when this happens, and we can try to understand how your feelings in the present are connected to memories in the past."

For Annie, however, it was not easy to tell anyone she was angry. And she resisted putting into words her affect, so clearly evident in her face and body language. When Mrs. Shapiro asked Annie what she thought Mrs. Shapiro might do if Annie became angry with her, Annie said, "Sometimes I get close to people—then I get mad. When I get mad they leave." Mrs. Shapiro reassured Annie that she could accept Annie's angry feelings and that she would not leave. With permission now to express anger, Annie's rage emerged in succeeding sessions, often in transference, and very slowly anger toward the objects of the past was reexperienced and put into proper perspective so that Annie could relate to her present family in a less conflicted way.

During all of these sessions, Mrs. Shapiro's watchful eye was upon Greg, always in the room. Would the rage spill over and engulf Greg? But once again, as in the case of Jane, we became witness to extraordinary changes in the young mother's relationship to Greg. In the midst of anger and tears, as Annie spoke of her own oppressive past, she would approach Greg, pick him up, enclose him in her arms, and murmur comforting things to him. We knew then that Annie was no longer afraid of her destructive feelings toward the baby. The rage belonged to the past, to other figures. And the protective love toward Greg, which now began to emerge, spoke for a momentous shift in her identification with the baby. Where before she was identified with the aggressors of her childhood, she now was the protector of her baby, giving him what had not been given, or rarely given, in her own childhood. "Nobody," said Annie one day, "is ever going to hurt my child the way I have been hurt."

Mrs. Shapiro, in her work, moved back and forth between the story of Annie's past and the present. She helped Annie see how fear of the parental figures of her childhood had led her to identify with their fearsome qualities. And as Annie moved toward a protective relationship with her own baby, Mrs. Shapiro fortified each of these changes with her own observations. Sometimes, speaking for Greg, Mrs. Shapiro would say, "Isn't it good to have a mommy who knows just what you need?" As Greg himself, now mobile, began to approach his mother more and more for affection, for comfort, for company, Mrs. Shapiro drew Annie's attention to each move. Greg, she pointed out, was learning to love and trust his mother, and all of this was due to Annie and her understanding of Greg. Annie was holding Greg now, cradling him protectively in her arms. We saw no more "playful" threats of beating and killing, such as we had witnessed months ago. Annie was

feeding the baby and using Mrs. Shapiro's tactful suggestions in providing the elements of good nutrition in the baby's diet.

In this family without traditions in child rearing, Mrs. Shapiro often had to be the tactful educator. In Annie's and Earl's families, even a 7-month-old baby was regarded as being capable of malice, revenge, and cunning. If a baby cried, he was "being spiteful." If he was persistent, he was "stubborn." If he refused to comply, he was "spoiled rotten." If he couldn't be comforted, he was "just trying to get someone's goat." Mrs. Shapiro always asked the question "Why?" Why is he crying, why is he being stubborn, what could it be? Both parents, perhaps initially surprised by this alien approach to a baby, began to assimilate Mrs. Shapiro's education. More and more, as the weeks and months progressed, we saw the parents themselves seeking causes, alleviating distress by finding the antecedent conditions. And Greg began to flourish.

This is not to say that within a few months we had undone the cruel effects of Annie's own childhood. But we now had access to this past. When Annie's voice sometimes became shrill and she gave brusque treatment to Greg, Annie knew as well as Mrs. Shapiro that a ghost from Annie's childhood had invaded the nursery again. And together they could find meaning in the mood that had suddenly overpowered her.

As the baby progressed and Annie's conflicted past became sorted out, we began to see one figure emerge in Annie's childhood who stood for protection, tolerance, understanding. This was Annie's natural father, who had died when Annie was 5. In Annie's memory he was kind and fair. He never beat her. He would never have allowed other people to be cruel to her, if only he had remained with the family. And as she spoke of her own father, love and a remembrance of his loss overwhelmed her. Whether Annie's memory of her father was accurate or not does not matter, of course. What does matter is that in the chaos and terror of her childhood there had been one person who gave her a sense of love and protection. In searching her past for something good, for some source of strength, this is what she found, and Mrs. Shapiro kept this good memory alive for Annie. We now understood another part of the puzzle. When we had first known the Beyer family, you remember, Annie had not only refused to care for her baby but regularly turned him over to her husband, the baby's father, for care. All of this had changed in the intervening months as Annie learned, through her therapist, how a mother too can be a protector to her child.

Greg himself began to show a strengthening of his bond to his mother within the early months of work. At 10 months of age, just before Mrs. Shapiro left for vacation, his behavior toward his mother showed selective response and seeking of her, much smiling and seeking contact with her, approaches to mother for comfort and for company. But

there was still some fear of mother, we saw, when her strident voice stopped him in the middle of some trivial misdeed.

During these months, we should now recall, Annie was pregnant. She rarely spoke of the coming baby to Mrs. Shapiro. It was as if the pregnancy was not real to her. There were no fantasies about the baby. She was fully preoccupied with her own self and with Greg, who was becoming the center for her.

In July, when Mrs. Shapiro was on vacation, Annie delivered a still-born child. When Mrs. Shapiro returned, Annie was sad and burdened with guilt. The death of the baby she thought was a punishment to her. She had not wanted the baby, and she thought God did not want a baby to come into the world who would not be loved. Many hours were spent in putting together the experience of loss and self-reproach. It was during this period too that Annie began to understand with help why she had not been ready for another baby. She was, indeed, drawing upon all of her impoverished emotional resources to give care and love to Greg, and in giving she felt depleted. Many times we had the impression that she was sustaining herself through the warmth and caring of her therapist, borrowing strength, augmenting the poverty of her own experience in love through the relationship to her therapist.

This was always a professional relationship, of course, but for a girl who had been emotionally starved and brutalized, this professional caring and understanding seemed to be experienced as the giving of love.

The unsatisfied hungers of childhood were persistent ghosts in this household. Often when the therapist arrived, Annie and Earl were watching television. Their favorite TV shows were children's programs and animated cartoons. This was not for Greg's sake, we must assure you, since Greg himself had no interest in these shows. During the summer of the Watergate hearings, which were carried on nearly every channel, of course, Mrs. Shapiro saw Annie and Earl switch from channel to channel until they found a program they liked. It was "The Jolly Green Giant."

When Mrs. Shapiro brought carefully selected toys for Greg (as we always do for our children when we know that the parents cannot provide them), Annie wore a conflicted look on her face. It was envy, Mrs. Shapiro realized, and longing. On one occasion, when Mrs. Shapiro brought some simple plastic toys for the baby, Annie said, in a voice full of feeling, "It's my birthday next week. I'll be seventeen." Mrs. Shapiro understood, of course. Annie wished the present were for her. The therapist, quickly responding, spoke of Annie's coming birthday and her wish that it be a very special day. Annie said, "I never had a birthday. I never had a party. I'm planning to have one for Greg in August. My mother will probably forget my birthday." (Her mother did

forget.) And for Annie's birthday, Mrs. Shapiro brought a small, carefully chosen present for her.

On Greg's birthday, Mrs. Shapiro brought a toy bus for the baby. Annie opened the package. She was enraptured. She examined each of the little figures, opened the bus door, placed all the little people on the seats, and only when she had finished playing with it did she give it to Greg and share her excitement with him.

#### THE LAST GHOST: THE MOST OBSTINATE ONE

The last ghost to leave the nursery was also the first ghost to enter it. And its name, of course, was "identification with the aggressor." Even in its most formidable aspect after the first months of therapeutic work this ghost no longer threatened the baby. That is to say, there was no longer serious danger of abuse of Greg by his mother. We saw how the strengthening of the love bonds between Annie and her baby protected the child from physical abuse. We also saw how Annie's remembrances of her own suffering became a form of protection to her baby. She would no longer inflict her pain upon her child.

At the end of the first year of treatment, then, Greg showed favorable signs of developmental progress and attachment to his mother. But the ghost still lingered, and we saw it in many forms that still endangered Greg's development.

As Greg became active, independent, curious, and mischievous in his second year, Annie's repertoire of disciplinary tactics appeared ready-made from the ruins of her childhood. Maternal and protective and affectionate as she could be when Greg was quiet, obedient, and "good," there was a voice for disobedience or ordinary toddler mishaps which was strident, shrill, and of a magnitude to shatter the eardrums. Greg at these moments was frightened, and Mrs. Shapiro drew Annie's attention to the baby's reactions on many occasions. And then very quickly, it seemed to us, Greg acquired a defense against the anxiety produced in him by mother's anger. He would laugh, giddily, a little hysterically, we thought. And this, of course, was exactly the defense which his mother had acquired in her childhood. Greg was 16 months old when we witnessed the appearance of this defense.

Very clearly an important component of Annie's defense—"identification with the aggressor"—had not yet been dealt with in the therapy. Annie had not yet fully experienced in therapy her childhood anxiety and terror before the dangerous, unpredictable, violent, and powerful figures of the past. From analytic experience we knew that the pathogenesis of the defense known as identification with the aggressor is anxiety and helplessness before the attackers. To reach this stratum of the defense structure through psychoanalysis is often a formidable

mothering of Greg, how identification with the feared people of her childhood was "remembered" when she became the frightening mother to Greg. It was a moment for therapeutic rejoicing when Annie was able to say, "I don't want my child to be afraid of me."

The work in this area brought about profound changes in Annie and in her relationship to Greg. Annie herself began to leave behind her tough, street-child manner, and the strident voice was muted. As the pathological identification with her own mother began to dissolve, we saw Annie seeking new models for mothering and for femininity, some of which were easily identified as attributes of Mrs. Shapiro.

And Greg himself began to respond to the changed climate of his home. As we should expect, the fear of mother and the nervous laugh as a defense against anxiety began to disappear. Since there were, in fact, strong bonds between mother and baby, there was much that Annie could now employ in an education of her son without fear.

Mrs. Shapiro enlisted the mother as observer of Greg's attempts to communicate with her. Concrete suggestions and demonstrations were offered in a supportive, noncritical way. This time Annie was able to use the developmental guidance in a less defensive and more constructive way, working in alliance with the therapist on behalf of Greg. Within a month of the time Greg's need for help in language was first identified, he began to use language expressively and was soon well within the normal range of the Bayley Scale.

Treatment continued for two years, which is some time beyond the point where Greg had achieved adequacy in all areas of functioning and Annie and Earl themselves had become competent and devoted parents. In large measure, the work of those two years was supportive of the two young parents who were coping with the stresses of "growing up" themselves, of completing their own adolescence, at the same time as they were learning to become parents of a kind they had never known in their own experience. Annie and Earl continued to seek guidance from Mrs. Shapiro in many areas of child rearing and yet were making good and wise decisions on their own as Greg moved into each new developmental stage. Treatment was terminated when Greg was 3 years old, when Annie herself told Mrs. Shapiro that she now felt good about her ability to manage without help. It was understood that at any time in the future that she needed to call Mrs. Shapiro or visit she would always be most welcome.

#### FOLLOW-UP

Since Annie and Earl kept in touch with Mrs. Shapiro from time to time, we have a follow-up report augmenting the story of this family. The outcome of treatment for Annie, for Earl, and for Greg has been

task. How shall we reach it through our once-a-week psychotherapy-in-the-kitchen?

We examined the pathways available to us. Annie's voice, Mrs. Shapiro had observed, would shift in a single moment from a natural conversational voice, which was her own, to the strident, ear-shattering voice which seemed to be somebody else's. But Annie seemed not aware of this. The alien voice was also incorporated in her personality. Could we employ the on-the-spot manifestations of this pathological identification in a two-phase interpretive process? First, to make the voice ego-alien, identify it; then, to interpret it as a defense against intolerable anxiety and lead Annie to reexperience her own childhood sense of terror and helplessness?

There was no difficulty finding the occasion in a home visit. The occasion, as it happened, appeared with startling clarity in a visit shortly after we examined the technical problems in our conference.

Greg, 17 months old, was in his high chair, eating his breakfast. Mother kept up a stream of admonitions while he ate: "Don't do that. Don't drop the food off." Then suddenly, responding to some trivial mishap in the high chair, Annie screamed, "Stop it!" Both Greg and Mrs. Shapiro jumped. Annie said to the therapist, "I scared you, didn't I?" Mrs. Shapiro, recovering from shock, decided this was the moment she was waiting for. She said, "Sometimes, Annie, the words and sounds that come out of your mouth don't even sound like you. I wonder whom they do sound like." Annie said immediately, "I know. They sound just like my mother. My mother used to scare me." "How did you feel?" Annie said, "How would you feel if you were in with a bull in a china shop? . . . Besides, I don't want to talk about that. I've suffered enough. That's behind me."

But Mrs. Shapiro persisted, gently, and made the crucial interpretation. She said, "I could imagine that as a little girl you might be so scared that in order to make yourself less scared, you might start talking and sounding like your mother." Annie said again, "I don't want to talk about it right now." But she was deeply affected by Mrs. Shapiro's words.

The rest of the hour took a curious turn. Annie began to collapse before Mrs. Shapiro's eyes. Instead of a tough, defiant, aggressive girl, she became a helpless, anxious little girl for the entire hour. Since she could find no words to speak of the profound anxiety which had emerged in her, she began to speak of everything she could find in her contemporary life that made her feel afraid, helpless, alone.

In this way, and for many hours to come, Mrs. Shapiro led Annie back into the experiences of helplessness and terror in her childhood and moved back and forth, from the present to the past, in identifying for Annie the ways in which she brought her own experiences to her

hopeful. In 1977, Greg—now close to 5 years of age—is seen in follow-up as a healthy, buoyant little boy, affectionate and endearing. A new baby brother, now 2 years old, testifies to the good mothering he is receiving and the good climate of his home. The marriage of Annie and Earl has become stable—and it is the only stable marriage in both their extended families. Annie herself is a proud and competent young woman. Last year Annie, the high-school dropout, enrolled in a class in child development. She was surprised, she told Mrs. Shapiro, to discover how much she knew.

She is consulted by all members of her family, including her mother, as family crises continue to occur. She dispenses wise counsel and keeps her own head. She thinks her mother and sisters all need therapy and has done her earnest best to persuade them, but not yet with success.

### The Questions—and a Hypothesis

We began this chapter with a question: "What is it, then, that determines whether the conflicted past of the parent will be repeated with his child?" Morbidity in the parental history will not in itself predict the repetition of the past in the present. The presence of pathological figures in the parental past will not, in itself, predict identification with those figures and the passing on of morbid experience to one's own children.

From the clinical studies of Mrs. March and Annie Beyer and from many other cases known to us in which the ghosts of the parental past take possession of the nursery, we have seen a pattern which is strikingly uniform: These are the parents who, earlier, in the extremity of childhood terror, formed a pathological identification with the dangerous and assaultive enemies of the ego. Yet if we name this condition in the familiar term, "identification with the aggressor," we have not added to the sum of our knowledge of this defense. Our literature in this area of defense is sparse. Beyond the early writings of Anna Freud which named and illuminated this defense in the formative period of childhood, we do not yet know from large-scale clinical study the conditions which govern the choice of this defense against other alternatives, or the dynamics which perpetuate an identification with the enemy, so to speak.

We are on sound grounds clinically and theoretically if we posit that a form of repression is present in this defense which provides motive

and energy for repetition. But what is it that is repressed? From a number of cases known to us in which "identification with the aggressor" was explored clinically as a central mechanism in pathological parenting, we can report that memory for the events of childhood abuse, tyranny, and desertion was available in explicit and chilling detail. What *was not remembered was the associated affective experience.*

Annie for instance, remembered her childhood beatings by her stepfather, and she remembered her mother's desertion. What she did not remember was terror and helplessness in the experience of being abused and deserted. The original affects had undergone repression. When the therapeutic work revived these affects, and when Annie could reexperience them in the safety of her relationship to the therapist, she could no longer inflict this pain upon her child. Mrs. March could remember rejection, desertion, and incestuous experience in childhood. What she could not remember was the overwhelming anxiety, shame, and worthlessness which had accompanied each of these violations of a child. When anxiety, grief, shame, self-abasement were recovered and reexperienced in therapy, Mrs. March no longer needed to inflict her own pain and her childhood sins upon her child. With the reexperiencing of childhood suffering along with the memories, each of these young mothers was able to say, "I would never want that to happen to my child."

These words strike a familiar note. There are many parents who have themselves lived tormented childhoods who do not inflict their pain upon their children. These are the parents who say explicitly, or in effect, "I remember what it was like.... I remember how afraid I was when my father exploded.... I remember how I cried when they took me and my sister away to live in that home.... I would never let my child go through what I went through."

For these parents the pain and suffering have not undergone total repression. In remembering, they are saved from the blind repetition of that morbid past. Through remembering they identify with an injured child (the childhood self), while the parent who does not remember may find himself in an unconscious alliance and identification with the fearsome figures of the past. In this way, the parental past is inflicted upon the child.

The key to our ghost story appears to lie in the fate of affects in childhood. Our hypothesis is that access to childhood pain becomes a powerful deterrent against repetition in parenting, while repression and isolation of painful affect provide the psychological requirements for identification with the betrayers and the aggressors. The unsolved mystery is why, under conditions of extremity, in early childhood, some children who later become parents keep pain alive; they do not make the fateful alliance with the aggressor which defends the child



ego against intolerable danger and obliterates the conscious experience of anxiety. We hope to explore these problems in farther study.

The theory posited here, however incomplete, has practical implications for psychotherapy with parents and children in those families where the ghosts of the parental past have taken up residence in the nursery. In each case, when our therapy has brought the parent to remember and reexperience his childhood anxiety and suffering, the ghosts depart and the afflicted parents become the protectors of their children against the repetition of their own conflicted past.

## VIII

# Billy: Infant-Parent Psychotherapy on Behalf of a Child in a Critical Nutritional State

VIVIAN SHAPIRO  
SELMA FRAIBERG  
EDNA ADELSON

IN THIS CHAPTER, we describe the treatment of Billy, who was referred to our infant mental health program at 5 months of age in a grave nutritional state. The baby was starving. His growth curve showed an ominous downward plunge which our pediatricians read as the profile of an infant moving toward the critical (and sometimes irreversible) state which is broadly covered by the term "failure to thrive."<sup>\*</sup>

Extensive diagnostic study of Billy revealed no organic cause for growth failure. His psychological status was equally alarming to the medical staff. And Billy's parents, a 17-year-old mother and a 21-year-old father seemed, themselves, to be depleted and without hope. There appeared to be no connection between the young parents and their baby.

At the time of referral, the progressive decline in Billy's growth and

<sup>\*</sup> A description of the "nonorganic failure to thrive" syndrome and a concise summary of the literature appears in the introduction to the case of Nina (Chapter V).