

RE: Request to do Grand Rounds

Dr. Davis called today to ask Selma to present at Pediatrics Grand Rounds on any of the following dates:

Tues., Nov. 11

Tues. Nov. 25

Tues., Dec. 23

TIME: 8:30am (1 1/4 hrs.)

The purpose of the session would be to acquaint residents either with our program or a case in which we are involved.

1. When do you need subject announced?
~~2. State period of 1 to check & Mo~~

9/15- Confirmed date. Davis will need subject by mid-Oct. Format is up to SF, but he wants to know whether she plans to use the full amt. of time.

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

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AND EDNA ADELSON

IN THIS PAPER WE DESCRIBE THE TREATMENT OF AN INFANT BOY 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 who was moving toward the critical (and sometimes irreversible) state which is broadly covered by the term "failure to thrive." The term "failure to thrive" describes those infants who show growth failure in the absence of any organic cause. In strict usage it is employed for infants whose weight has fallen below the third percentile. It is almost universally associated with the impairment of the mother's capacity to nourish both in the concrete and in the psychological sense of the word.

The typical course of medical treatment for a failure-to-thrive

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infant is hospitalization with intensive one-to-one nursing care. With nurse-mothering and the introduction of a good nutritional regime, the baby begins to thrive. When his nutritional state is stabilized, he returns to his home. Typically, these gains are lost within a few weeks and the baby may return to the hospital again—and the cycle renews itself.

It is the mother who is the key. Whether or not the baby will thrive outside of the hospital depends upon the mother's capacity to follow the medically prescribed regime to insure adequacy in caloric intake for her baby and to provide the psychological nutriment for growth and development. But the dietary advice given by the hospital and the later guidance which focuses only on caloric intake and omits the developmental needs of infants are not successful (Whitten et al., 1969). All reports agree that families of failure-to-thrive infants are difficult to reach and to engage in continuing contracts. However, a more favorable outcome is reported by Leonard et al. (1966) and Barbero and Shaheen (1967) when mothers were able to collaborate with the physician, social worker, or public health nurse in a satisfying relationship established during the child's hospitalization and continued into the posthospitalization period. Barbero and Shaheen describe their experience in which parents are encouraged to become active members of the hospital care team. They speak with feeling for the parents who see the child's improvement during hospitalization as a threat to their competence. "It is around this point that the art of the physician is required to avoid such injury to the parent" (p. 644). In evaluating their experience, Barbero and Shaheen conclude: "Early case-finding and diagnosis are vital links in the process of intervention" (p. 644).

In our own experience at the Child Development Project we have benefited in several cases from "early case finding." We are indebted to the pediatricians, nurses, and social workers at the University of Michigan's Mott Children's Hospital who read the ominous signs in a child's nutritional state and a mother's incapacities to nurture.

Our Infant Mental Health Program brings the skills of a psychiatric team into the home. Clinical assessment of the child and his family and close collaborative work among the clinical special-

ists on our staff are carried out within the framework of home visits. The treatment program which evolves is provided by one primary therapist who may be a social worker, a clinical psychologist, an educational specialist, a pediatric nurse, or a psychiatric resident. The therapy is conducted in the family living room (or the kitchen). The baby as patient is usually present with one or both of his parents. The sessions are, of course, focused upon the baby and his development, the parental concerns, and inevitably the conflicts which are impeding the parent in his or her relationship with the baby. Our concerns for the parent as well as the baby have made us welcome visitors to many "hard-to-reach" families.

"Back at the office" there is a supporting team for every therapist and every family. The therapist—even the expert with years of clinical experience—discusses his case with a consultant in regularly scheduled sessions. We have found this plan vital to the conduct of our program. The work with infants in jeopardy and their parents is painful, often emotionally depleting to the therapist. To sustain energy, hope, and objectivity; to insure that the best professional resources of our clinic are brought to the treatment program for each child; to examine the treatment process in fine detail—we need each other and use each other's support and expertness.

Our work is guided by psychoanalytic principles and two of our senior staff members are child psychoanalysts who participate in the case review and planning in all intensive treatment cases. However, the treatment program for each family is properly speaking a collaboration of disciplines in which social work, clinical psychology, developmental psychology, special education, pediatrics, medicine, and nursing are united with psychoanalysis in every phase of the work.

In the case of Billy and his teenage parents which we describe in this report, Vivian Shapiro was the primary therapist, Edna Adelson and Selma Fraiberg were the consultants.

BILLY AT 5 MONTHS

Billy Douglas was referred to our project by the Child Health Center at the University of Michigan Medical Center when he was

5 months old. Billy vomited after each feeding. He had not gained weight in 3 months. He was a full-term healthy baby, whose birth weight of 8 pounds put him in the 70th percentile. At 5 months he weighed only 14 pounds 5 ounces and was in the 25th percentile. He had become a tense, morose, somber baby who looked, in the doctor's words, "like a little old man." Dr. Robert Larson, then a pediatric resident at the Child Health Center, had worked intensively with Billy and his young mother for 2 months. Sensing the potential gravity of Billy's situation, he had begun to see Billy and his mother weekly at the outpatient clinic. He did extensive diagnostic studies and tried various medical interventions. He was puzzled, however, because there seemed to be no observable medical explanation for Billy's feeding difficulties. He also realized that the mother was becoming increasingly depressed.

Kathie Douglas was an anxious 17-year-old girl who had married Billy's 21-year-old father, John, only 2 months before Billy's birth. She was often unable to carry through with suggestions regarding food and medication. Dr. Larson called in a public health nurse to see Billy and his mother weekly at home. Despite their best efforts, however, the doctor and the nurse observed that Kathie and Billy were not responding to their advice. At 5 months Billy's situation was critical. He was regressing and hospitalization was being considered. Further, Kathie seemed even more depressed, distant, and sometimes confused.

The medical team decided to make a referral to our Project. They requested both immediate clinical assessment and possible treatment for Billy and his mother. They were not certain there was a connection between the baby's health and the mother's deteriorating emotional status, but they felt that a better clinical understanding of Kathie and her baby might help explain why Billy was physically regressing and also indicate what psychological and medical interventions were needed.

CLINICAL EVALUATION

Our first task, then, during this medical emergency, was to make a psychological assessment of Billy and his family. The therapist

began twice-weekly visits to the home for direct observation of the baby, his parents, and their modes of interaction.

Under all ordinary circumstances we devote approximately 5 weekly one-hour sessions to the clinical evaluation period. In Billy's case, the nutritional and psychological perils were so great that we knew, after the first three visits (1½ weeks), that intervention on a concrete educational basis must begin before the psychological complexities were fully understood. These earliest visits, however, gave us vital clues which we could pursue in the emergency period.

INITIAL OBSERVATIONS OF BILLY AND HIS PARENTS

When the therapist first arrived at the Douglas's small apartment, she met a timid, sad-faced 17-year-old girl, who was Billy's mother, and a gaunt young man, the father, barely out of his teens, who was so uneasy that he did not acknowledge her presence until almost the end of this visit.

The therapist's first impression of Billy brought the doctor's words to mind. "Billy looked like a little old man." Billy was in his crib. He was up on his hands and knees, staring at the door, when she entered the room with his mother. His eyes met the therapist's with an intense stare and a fixed smile. His stare never wavered.

Billy was motorically very precocious and was able at 5 months to turn over quickly, to creep, to grasp and manipulate objects. On the whole, however, he was a very tense baby. All of his movements and efforts at communication had an urgency that was unusual in a baby of this age. When the therapist held him for a moment, she could feel the strain and tension in his body.

Billy seemed unusually aware of sounds. In particular, his mother commented that Billy responded quickly to any sounds related to feeding. She illustrated this by opening the refrigerator door while Mr. Douglas held the baby. Billy almost jumped out of his father's arms, his mouth opened, anticipating food, and his whole body strained toward the refrigerator. As his mother approached him with an eyedropper with vitamins, Billy, still in his father's arms, leaned back, opened his mouth, his hands became inert, and he looked like a starving baby bird awaiting food from his mother. Mother and father seemed uncomfortable with Billy. They treated

him like a newly arrived stranger whom they had to approach cautiously and from a distance.

In early home visits the therapist saw that Billy spent his day either amusing himself on the floor or in bed. He was capable of spending a lot of time in solitary play with toys. There were few signs of human attachment. Even though he could creep, Billy rarely approached his mother. He rarely made eye contact with her. He rarely smiled unless his mother used gross tactile play. When he fussed his mother put him to bed with a pacifier and honey.

Billy's mother said sadly that Billy did not enjoy cuddling. She said that when she held him in her arms, he seemed to turn away from her. In fact, neither mother nor father held Billy in a close ventral position. They held him so that he was constantly facing away from them.

Already, it was obvious to us that this baby and his parents were out of synchrony with each other. There was none of the normal spontaneity or joy in mutual gazing one would expect between parents and baby at this age. Billy was a somber, tense baby who seemed to be starving. His mother was also morose and somber and, as we shall see, both parents were hungry and starving in their own way.

We soon learned that this new family was in a state of great stress and deprivation. They were living in poverty, supported only by Mr. Douglas's small earnings and food stamps. In addition to the financial stress, Mr. and Mrs. Douglas had lost the support system of their extended families by their move to a strange city. They felt abandoned and overburdened. There simply were not enough financial or emotional resources in this new family unit to satisfy the needs of mother, baby, and father.

Correction → Billy's mother, at 17, seemed pathologically young and childlike. Her schoolgirl face, her T-shirt bearing a high-school insignia, gave her the appearance of a girl surprised by the events that had brought her to motherhood.

In response to the therapist's comment that this year must seem different from last year when she was still at school, Kathie spoke of her feelings of loss. She missed her hometown, her high-school friends. She missed going to school. So much was unfinished and

now everything had come to an end. In her mind Kathie was not Mrs. Douglas; she was a misplaced teenager keeping house. All this emerged in a sad and distant voice. The therapist was struck by the depth of Kathie's depression, which was evident in her posture as well as in her words. Her range of affect was constricted. Her movements were slow. Her speech was halting, and she seemed distant and sometimes confused. She rarely made eye contact with the therapist.

The full weight of Kathie's depression soon became evident. She said that most of the time she was holding back feelings of rage that were so strong that "if I let go, I would kick the walls out of the house." She was having many somatic complaints, headaches, backaches, gynecological problems, and was also overweight. She sadly spoke of herself as feeling and looking like a fat old lady. She felt guilty about imposing on her husband for his time and attention.

John Douglas was also very young. At 21, he was haggard, thin, frightened, and embarrassed by difficulties he could no longer cope with by himself. He was much more hesitant than Kathie to engage in any interaction with the therapist. He literally turned away from her during her first few meetings with him. When he did talk to her, it was through a teasing question to Billy. "Billy, do you want to go home with her?" We believe he was simultaneously expressing his ambivalence about Billy and questioning the therapist's attitude toward his own worth as a parent. The first time he directly looked at her and smiled was about a month after she started visiting when he told her that Billy seemed happier, that he liked to play more.

Billy's state and his feeding problem made intervention imperative, yet, after two sessions in the home, we had not yet observed a feeding which would provide tangible clues. Although the therapist had arranged to come at mealtimes, Kathie avoided feeding Billy in her presence. Kathie was, perhaps, not yet sure of her, not yet ready to reveal herself in the situation in which she was most inadequate. It was in the third session that Kathie volunteered to let the therapist see how Billy was fed.

HOW IS BILLY FED?

As part of our assessment a video play session was arranged at our office playroom. This session was primarily planned so as to permit

the baby's own play as well as spontaneous mother-baby interaction.¹ What occurred gave us a sobering picture of the isolation and the estrangement of baby and mother. As if he were alone in the room, the baby engaged in solitary exploration of toys and furniture. He never once sought his mother with his eyes. He was mobile, but never crept toward his mother. His mother looked distant and self-absorbed.

Then Billy uttered sounds of complaint. His mother said that it was time for his bottle and volunteered to feed Billy. She said, "Watch what he does when I show him the bottle." She placed the bottle on the floor, several feet away from Billy, who was on hands and knees. Billy's face registered alertness and urgency—no smile, but urgency. And the 5-month-old baby began to creep the long distance toward the bottle. He reached for it unsteadily, but could not quite grasp it. Finally he did grasp it, mouth open hungrily, but it was bottom up. He could not quite orient it. At last he got the nipple into his mouth. He sucked solemnly, greedily.

While the therapist watched this scene, masking her inner pain and horror, the schoolgirl mother explained that this was the way Billy took his bottle. "He likes it that way. He likes to have his bottle alone, on the floor."

After a while the therapist suggested that Mrs. Douglas sit with Billy in our rocking chair and feed him. The second observation gave us another piece of the puzzle. Kathie now held Billy loosely in her arms. Billy was still supporting his own bottle. The mother, looking tired and apathetic, said that Billy usually finished his bottle in 4 minutes. "Sometimes, however, if the bottle is slow, it takes an hour." She talked as though it were his feeding, not something that she had anything to do with. She herself looked

1. We customarily videotape a play session and Bayley testing at this point in an assessment. This is done only with the consent of parents, of course, and we do everything possible to make the taping nonintrusive. We never invite intimate discussions at these times. We do not use video for treatment sessions, but we find that the taping of play sessions and testing is almost always of great interest to parents, and the playback of the tapes for the parents is valued by them and by us as an opportunity to observe the baby and themselves. In Billy's case because of the urgency of the feeding problem, a formal Bayley testing was postponed until nutritional adequacy was achieved at 7½ months.

How we
feel

distant and empty. Our impression was that although Billy was in his mother's arms, he was still feeding himself. There was no mutual gaze, and little tactile contact. The mother was right: the baby turned away from her. She looked uneasy and sad and sometimes irritated.

Later in this visit Kathie started to rock herself in the rocking chair while holding Billy loosely in her arms. She looked like a little girl rocking herself, almost a parallel play situation, the hungry adolescent mother rocking and nurturing herself, allowing her baby to drink his bottle in her arms. Yet, as cold as the scene appeared to us, Kathie seemed to get some pleasure from this unusual closeness between herself and Billy. While watching this videotape later she commented that this was in fact a good feeding, a better feeding than usual.

WHY CAN'T KATHIE FEED HER BABY?

As a treatment team we reexamined the videotape and the detailed notes of the home visits. We asked ourselves, "Where shall we begin? This is a schoolgirl mother who cannot feed her baby and who avoids physical contact with him." To encourage intimacy in feeding leads at best to mechanical compliance, as we saw on tape. There were few rewards for mother or baby.

Yet, we must promote this intimacy and proper feeding and we must, at the same time, seek the answers to the crucial diagnostic questions that will lead to help. What lies behind the avoidance of physical contact? Is it the destructive rage which Kathie had expressed in her first session? "I could kick the walls out of this house." Is it the mother's own unsatisfied hungers, body hungers as well as psychological hungers, which have led her unconsciously to withhold love and nourishment from her child? Was there something else on the mother's face and in her voice and manner as we watched the video story. An aversion to feeding? Disgust?

We would have to find out much more. But a teenage girl, even under more favorable circumstances, does not give her trust so readily to a helping person. We would need time to explore the dimensions of this conflict. But this teenage girl was a mother, her baby was our patient, too—and the baby was in great peril.

No case report can ever do justice to the feelings of the therapist who works with infants and their parents. There is an urge to rescue the baby who is in danger, to mother him oneself. There are deep reproaches, even anger toward the schoolgirl who is starving her baby, which must be expressed and which must be dealt with by the therapist lest it intrude in the work. In this situation we were helped by the fact that all of us are child therapists. We saw the mother herself as a child, an unfinished adolescent who still needed a mother herself. She was frightened, helpless, hungry, depleted. This did not imply that the therapist must become a mother or a mother substitute, but if we understood the child who was the mother and responded to her feelings of anguish and deprivation, we might earn her trust. Only on this basis was there hope for treatment.

In the home visits that followed the illuminating feeding session, Kathie began to respond to the therapist's deep concern for her as well as the baby. She began to speak of deep revulsion in the feeding of Billy. She was repelled by Billy's vomiting, she confessed, and had been since his birth. She was sickened by the sight, the messiness. The therapist saw for herself the horror and panic which came over Kathie when she anticipated—or only imagined—that the baby was going to spit up or vomit.

At the end of a bottle feeding (Billy was taking his bottle on the floor), Kathie hurriedly picked up Billy to burp him. We would expect, of course, that she would hold Billy upright against her shoulder. Instead, she rushed to the bathroom with the baby, faced him over her arm so that he was hanging over the bathroom sink—and Billy vomited his meal into the sink. In this way Kathie avoided her worst fears that the baby would throw up in her arms. And the strategy that she employed virtually guaranteed that the upside-down baby would throw up his dinner!

Until the therapist discussed her observations with Kathie, it had not occurred to the mother that she was precipitating the baby's vomiting. In her mind the only alternative was dreadful: to have the baby vomit in her arms.

Thereafter Kathie could tell us more. She had noticed that when Billy was 3 months old and had begun taking solids in his diet, the hue and texture of the vomit had changed. She was so repelled that she reduced Billy's solids to a minimum as a way of avoiding the

revolting mess. We now had another vital clue: the decline in Billy's weight curve had started at 3 months.

What, in fact, constituted Billy's daily food intake? Kathie was not sure. During the first visits the therapist often heard Billy's piteous cries of hunger. When she said to both parents that Billy seemed very, very hungry, they were astonished. The father said, "Do you think he is still hungry? I think he is just like me. I could never be satisfied. I could eat everything that was given to me right now." The mother said resentfully that Billy never seemed satisfied; he was always begging for food. "If we gave him everything he wanted, he'd eat us out of house and home."

It soon became clear that neither of these young parents had any real sense of how much food Billy needed. Actual hunger was part of their daily experience and they had to limit severely their own appetites in many ways. At some level both Kathie and John seemed to feel that Billy would simply have to share in their hunger. Apparently, they did not fully understand that his life was at risk.

ASSESSMENT AND INTERVENTION PLAN FOR THE EMERGENCY PERIOD

Our initial assessment gave us many of the vital clues to Billy's feeding problem. Billy was starving. But he was not "refusing" food, he was being deprived of food. The vomiting, according to our observations, was induced by his mother's unique procedures for burping, which were in turn related to her dread of being defiled by vomit.

The psychological picture was beginning to emerge: a teenage mother who avoided contact with her baby; a baby who crept toward his bottle on the floor and fed himself; a mother who had a deep inner revulsion against messiness and possibly toward the baby himself; a mother who was afraid of her own destructive rage; a mother who was an adolescent with unsatisfied bodily and psychological hungers.

The baby was in nutritional peril and in great psychological peril, for in none of our observations did he show signs of attachment to either of his parents. At an age where preferential smiling and vocalization should emerge toward the baby's partners,

we saw none. At an age where the baby normally seeks eye contact with his partners, we saw gaze avoidance. At an age when a mobile baby seeks his partners through his own mobility, Billy sought no one. He did not enjoy closeness in his mother's arms, and was stiff and resistant in the arms of any human partner. His mental abilities seemed well within the Bayley ranges, which testified for some adequacy in stimulation and experience.² But what could not be measured through any existing scale was the effect of emotional impoverishment and unsatisfied body hungers in this baby, now almost 6 months old.

At this point we faced a therapeutic dilemma. As clinicians we knew that the psychopathology of these young parents, and particularly the mother, would not be accessible to us within a few weeks, but the baby could not wait for the resolution of his mother's neurosis.

In this medical and psychological emergency we formulated our plans for the first phase of treatment. We would concentrate on the feeding problem, giving direct advice and guidance. We would do everything possible to promote the attachment of baby and mother. We would use our clinical insights to guide us during this emergency period, but we would not expect to gain full understanding of the parental psychopathology at this time.

The transference to the therapist would be fully utilized in this emergency period. This was an adolescent girl with her own developmental needs. The therapist's professional caring could be a form of nurturance for the mother. The adolescent need for identification models could be employed in a sensitive offering of this professional help.

THE EMERGENCY PERIOD OF TREATMENT

The period that we speak of as "emergency treatment" lasted for 2 months. It was really synchronous in time with the assessment period. During this period Billy began to eat normally, the vomiting virtually ceased, and he began to gain weight in a stable and satisfactory manner.

2. We did not observe Billy engage in age-related social personal behavior, such as frolic play and early vocalizations.

THE THERAPEUTIC RELATIONSHIP

The therapeutic sessions with Billy and his mother took on a pattern that was set by Kathie. She had chosen a meeting time at home shortly before Billy napped. At the beginning of each visit, the focus was on Billy. Either the therapist and Kathie would observe Billy playing or Kathie would feed him or have some questions or—more often—complaints about Billy. Usually, midway through the visit, Kathie would put Billy to bed and the remainder of the time would be hers.

The therapist found out very quickly that if she responded to Kathie's own needs and feelings, either covertly or overtly expressed by her, Kathie would soon, and often in the same session did, attend to some of Billy's needs. For example, as the therapist acknowledged that she understood how hard it was for Kathie to try and hold a baby who turned away, Kathie was able to hold Billy with tears in her eyes instead of putting him down.

Many aspects of the positive transference became available to the therapist in helping Kathie on behalf of Billy. Kathie was initially very dependent and related to the therapist as a child to mother. (For example, when the therapist visited, she had to let herself in, hang up her coat, find a place to sit down while Kathie often continued to sit slumped in a chair in the living room.) The therapist responded to Kathie's need for a mother, while taking care, of course, to offer her another kind of "caring for Kathie" which was part of a therapeutic relationship.

The therapist sympathized with Kathie's sense of loss in leaving her own family and in leaving childhood as an unfinished adolescent. She responded to Kathie's feelings that no one cared for her and that she was physically deteriorating. She helped to arrange free medical service for Kathie at a health clinic which had been available but which she had not been able to seek out. She encouraged Kathie in her efforts to finish high school, and praised her for any accomplishments regarding her own efforts to continue her artwork.

We knew that Kathie felt inadequate, had been told she was by her mother, and in a sense by Billy himself as he repeatedly seemed

to reject her food. The therapist was very careful not to compete with Kathie in any way for Billy's attention, nor did she actually intervene and do things for Billy, even though at times she could hardly restrain herself. It was important for Kathie to feel that the therapist, as a child consultant, identified with her as a mother facing problems in caring for her baby and that she had confidence that Kathie, with her help, could give Billy what he needed to be a healthy baby. Together they observed Billy, his preferences and his dislikes and took joy in any of his accomplishments. Billy's accomplishments were always related back to Kathie's efforts. The therapist especially shared her observations with Kathie of any special feeling that Billy expressed toward her, as his mother, such as a preferential smile or a reaching out to her. Kathie's feeling of failure was so strong that she was amazed when Billy preferred to go to her rather than to the therapist. She clung to any bit of evidence that Billy liked her. When she saw the scene of herself in the rocking chair with Billy, she said, "That looks so peaceful. Billy looks so contented."

GUIDANCE: INFANT NURTURE AND MOTHER NURTURE

Within this framework, and relying very largely upon the positive transference, the therapist introduced suggestions for feeding and burping Billy that were effective in a very short time. While these issues are treated topically in the pages that follow, they were actually concurrent and interwoven in every session.

The first concrete changes came in Kathie's willingness to try to hold Billy for a feeding. Kathie had said that Billy did not like to be held; she knew this because he turned away. The therapist commented that even though Billy turned away, his body seemed to be more relaxed and she thought this indicated that he did like his mother to hold him. It was obvious that Kathie's bland, sad face could not hold Billy's attention when she was trying to feed him in her arms. One time, as the therapist watched Kathie try to feed Billy in her arms, Billy repeatedly turned away. Seeking a tactful way to guide Kathie to a livelier exchange with her baby, the therapist asked her if she ever told Billy stories. She said, "No." The therapist asked if she could tell Billy a story while Kathie held him

and she agreed. The therapist began her story, "Once upon a time there were three bears," using what Stern (1973) describes as "normal baby talk expression"—elongation of smile, rise and fall of voice, exaggerated nuances. All of these are typical exchange behaviors between baby and mother. All were missing from Kathie's conversation with Billy.

Billy and his mother both loved the story. Billy began to smile and make eye contact with the therapist and his mother, as together they watched him. Kathie so enjoyed this herself, as both child and mother, that she herself began to tell Billy stories and, of course, Billy quickly began to respond. However, this took so much effort on Kathie's part that she was often fatigued and once again lapsed into her silent behavior.

A major concern was the burping process. The therapist had made many suggestions to Kathie about burping Billy, and had tried to help Kathie understand how her method would precipitate vomiting. It was only when the therapist actually stood beside Kathie, however, and shared with her the tension she was feeling, as she put Billy gently over her shoulder with the diaper underneath him, that she was gradually able to begin burping Billy in a normal fashion.

Kathie began to feed Billy the bottle in her arms on a regular basis, but did not yet give him solids. During a number of interviews it became clear that this was part of more complicated feelings about feeding Billy. At this point we identified two fears: Kathie's fear that "Billy would eat the family out of house and home" and that he would throw up endlessly.

While we recognized that these fears were deeply rooted in Kathie's personality, we knew that we could not uncover the origins of these fears in the emergency period. And Billy's needs were paramount. We would have to help Kathie in a concrete, educational way to provide caloric adequacy for Billy.

The therapist could use the positive transference in supporting Kathie step by step in a feeding program for Billy. It was futile, of course, to challenge Kathie's irrational belief that Billy would "eat the family out of house and home" or that he would "throw up endlessly." The therapist only sympathized with Kathie's fears and led her gently into a collaboration on Billy's behalf.

With pencil and paper and measuring cups the therapist and Kathie worked out quantities and sample feedings. We soon saw that Kathie could follow this regime. Long afterward we are still wondering how this was possible in view of the fact that quantities of food were still bound to profound conflicts in Kathie. Our best guess is that the objective, "on paper" feeding plan relieved Kathie of the responsibility for dealing with her own unconscious and dangerous impulses toward her baby. The therapist, "siding with the ego," was lending her own quiet authority to support Kathie's positive strivings to mother and her defenses against the destructive wishes.

In many discussions with the therapist, Kathie expressed her fear and revulsion of Billy's throwing up. The therapist acknowledged that she could understand how especially difficult it was for Kathie to hold and feed Billy. She told Kathie that together they would pay special attention to ensure that Billy would not throw up through overeating and that she wanted Kathie to observe carefully how much he ate and whether or not he threw up. With much relief that the therapist understood her difficulty, Kathie agreed to place Billy on a solid feeding schedule, which she and the therapist monitored carefully.

Billy began to gain weight steadily. Vomiting virtually disappeared. By 7 months Billy had gained $2\frac{1}{2}$ pounds and reached the 50th percentile in weight; Dr. Larson was satisfied that Billy was no longer in nutritional peril (see fig. 1).

THE FAMILY'S PROGRESS

During the time this work was progressing, we were, of course, concerned with the well-being of the whole family, Mr. and Mrs. Douglas and Billy. An important part of the work was the help that was given Mr. Douglas. He came from a large, impoverished family and had suffered physical and emotional privations in his own childhood. As a young husband and father he was again struggling with poverty and hunger, and his depressed young wife drained his emotional resources. Each member of the family was hungry for physical and emotional sustenance. When John was home, he, too, shared his worries with the therapist, who responded with sympa-

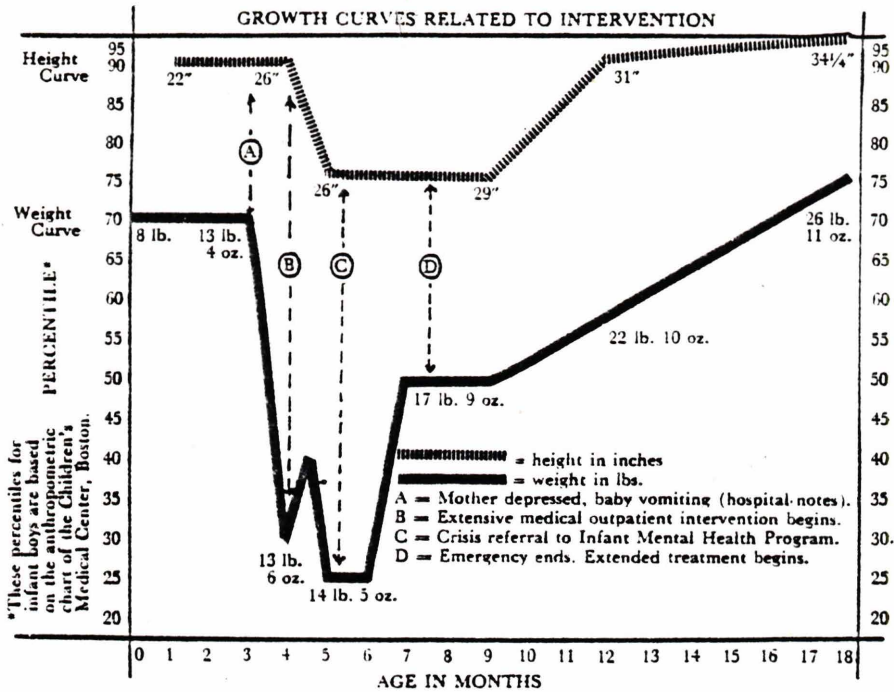


Figure 1

theric understanding and with attention to his problems. She helped John and Kathie find ways to work out their present financial difficulties. She let them know that their hunger was her concern as well.

In summary, the work during the emergency period brought Billy to nutritional adequacy and his parents had formed a strong alliance with the therapist on behalf of their baby. Kathie, however, was still depressed, and we remained concerned about her and Billy.

Chart here.

THE EXTENDED TREATMENT PHASE

REASSESSMENT

The period that we speak of as the extended treatment phase carried the work with Billy and his parents for a full year beyond

the emergency period. While Billy had made progress, we still regarded him as a baby "at risk" in the psychological sense.

In the area of human object relations we saw much we considered ominous. Billy did not respond to his parents in ways that were appropriate for a child of his age. Billy still avoided eye contact with his mother, by turning away. He preferred play with toys rather than human partners. When he was hungry or in need, he still cried helplessly and piteously.

It seemed to us that Kathie was now able to follow much of the therapist's advice, but her responses were always mechanical. She was still unable to mother Billy in a harmonious and spontaneous manner; she still seemed estranged from her baby. She appeared to hold back food and only slowly responded to Billy's hunger cries. She was not empathic with Billy's attempts to communicate distress or hunger. The interaction between mother and baby was still erratic, and Billy could never really count on a pleasurable response from his mother. Very often Kathie teased Billy with food and seemed to be competing with him.

As part of our continuing assessment, when Billy was 7½ months old, we videotaped another playroom visit which included a Bayley developmental assessment and a spontaneous feeding.³ This tape spoke eloquently for the mother's ambivalence toward her baby and for pathological tendencies in both.

In one scene Kathie was holding Billy in her arms in a close and tender way while she was feeding him his bottle. Suddenly, Kathie pulled the bottle away, tossed back her head, dropped some milk in her own mouth, and then engaged Billy in a teasing game, in which she was competing with him for his bottle. It was painful to watch, but more painful was our witness to the baby's reactions: he was laughing. He had become a partner in this sadomasochistic game, a game that was repeated several times.

We have learned to give such "baby games" serious clinical attention. Some of our most important clinical insights have been derived from observing parents at play with their babies. The

3. The Bayley showed that Billy was slightly above the median, in both mental and motor scores overall, but differentially lagged in beginning language items.

parent in conflict frequently reveals the essence of the conflict in play, in the "harmless games" (Fraiberg, 1974).

What we saw on tape, then, was a young mother competing with her own baby for his bottle. The moments of tender mothering were interrupted by an intruding thought, and feeding the baby became "teasing the baby," "taking food out of his mouth," "jealousy," "competition." As we watched this tape as a staff, we were struck by the thought that the mother behaved as if her baby were a sibling—and at that point the story began to come together for us.

THE GHOST IN BILLY'S NURSERY

By this time we had come to know a fair amount about Kathie and her own childhood. In the emergency phase of treatment, this was information which we could register and store, but could not put to use for Kathie's treatment. Kathie had regarded herself as the unwanted middle child of her family, the no-good child who could "never do anything right." While Kathie had spoken with some acidity about her mother and her older sister, she could barely control her rage when she spoke about Essie, her sister younger by 5 years. "Essie got everything," she said bitterly. Her memories of Essie, which may have been distorted, linked Essie to food in many ways. One of the bitterest memories, possibly a screen memory, was of a time when Kathie's parents took Essie out for an ice-cream cone and left Kathie home to do the dishes. Essie was the good child, the child that Kathie's mother favored.

We knew that Billy had been the "intruder" in Kathie's current life, the unwanted baby, the baby who "spoiled everything" for her, the baby who was taking food out of her mouth. There was a ghost in Billy's nursery, we thought, and the name of the ghost was Essie. Essie was the first intruder, the first baby in Kathie's life, who deprived her of the good things in life, of mother, and, in symbolic terms, of food.

If we were right, the therapeutic problem for us was to get the ghost out of the baby's nursery. We would need to help Kathie deal with the repetition of the conflicted past in the present, to disengage Billy from the figures of the past.

THE INFANTILE CONFLICTS AND REPETITIONS IN THE PRESENT

Our treatment during this period united guidance on behalf of Billy and a therapy which explicitly focused on Kathie's conflicts in mothering and their origins in her own childhood conflicts. The setting remained the same: home visits, scheduled twice weekly. Kathie was a willing and eager collaborator in her own treatment, to find out "why" she felt herself the victim of her own past.

Typically, the sessions would begin with Billy in the living room or the kitchen, and the therapist and Kathie would speak about his progress, or discuss any of Kathie's questions. The therapist continued, of course, to offer her observations and to help Kathie observe Billy, to interpret his needs and his signals, to praise his accomplishments and her own growth as a mother. Kathie's own needs for the therapist's time sometimes brought her into competition with Billy. Billy always had "his" time, during part of each session, and sometimes when Kathie felt most urgently in need of time with the therapist, she would say, "Shh, Billy, it's my turn now." Usually, the visits were timed so that Billy's nap would divide the time and give Kathie some time for privacy.

In nearly every session childhood grievances appeared with more and more intensity. But vitriolic hatred toward Essie, the first intruder, dominated many of these hours.

The transference was employed both to open up the past and to offer Kathie, the "unfinished adolescent," a new figure for identification and for undoing the powerful effects of her own mother, remembered as rejecting, critical, suspicious, and harsh, the "witch-mother" of early girlhood and adolescence.

The flow of memories converged again and again on the time following the birth of Essie, a period which marked a profound shift in Kathie's relationship to her own mother. Allowing for much distortion in adolescent memory, the figure of Essie, the baby who robbed Kathie of her mother, and the figure of the mother who "rejected" Kathie for the new baby were persistent ghosts. Along with these memories came overwhelming feelings of grief, depression, mourning for herself as a neglected, unwanted child. These were the feelings which had been revived with the birth of Billy. In Kathie's living room, with her own baby, the therapist often had

the eerie feeling that she was witnessing another time, that Kathie was again the bereaved 5-year-old robbed for the second time by a baby. Motherhood had brought regression, and Kathie was locked once again in the infantile conflict.

The relationship with the therapist opened up many pathways for "undoing." "My mother never listened to me," was Kathie's reproach, a recurrent theme in these hours, but the therapist listened and responded to Kathie's feelings of grief and rage. "My mother said I was bad. It was bad to hate my sister." The therapist acknowledged and accepted the feelings of jealousy and anger toward the sister "who got everything." "My mother never understood me." The therapist explicitly told Kathie that she wanted to understand her. "My mother said I couldn't do anything right." The therapist, siding with Kathie who wanted to "do things right," could give honest support to the many aspects of Kathie's growth as wife and mother in which she showed her good capacities. Since Kathie believed that her own mother did not find satisfaction in motherhood and did not provide a model for mothering that Kathie felt she could use, the therapist shared many moments with Kathie when she received great satisfaction with Billy. Moreover, she offered an alternative model for mothering, which Kathie could use if she wished.

When muted or sullen anger appeared in the transference, the therapist helped Kathie put her anger into words and to discover that the anger would not destroy the therapist, or the positive relationship to the therapist, and could, indeed, open pathways to the conflicted past and ways to find meaning in that anger.

We now select themes from the work of this period. In the process of treatment these themes were, of course, interwoven.

KATHIE, ESSIE, AND BILLY

The story of Essie, the first intruder, emerged as a central theme in Kathie's sessions when Billy was 8 months old. Kathie was still a reluctant mother to her baby, mechanically following the advice on feeding, now holding Billy for feedings and providing adequacy in caloric intake, but with little spontaneity or joy in her exchanges with the baby.

As memories of Essie emerged with rage toward that first baby

"who spoiled everything," and as grief for herself as a small girl was revived, we began to see, for the first time, a spontaneous reaching out to Billy. The therapist described this in an excerpt from a visit with Kathie when Billy was 8 months old:

I had asked Kathie if she could tell me what it was like for her when her own baby sister was born. She said, "I've told you I hated my sister, how she always came between me and my mother. I don't remember much. When my sister was little, I remember being outside of the house much of the time. I do remember a couple of things. I didn't want to play with her. I hated to be told to play with her and I told my father that I hated her."

At this time, Kathie had her hand raised and was shaking it in the air. (I think she was nonverbally imitating her father talking to her and speaking for her father.) She said, in a deep voice, "No child of mine can hate another sister, you play with her."

After a while Kathie continued: "The first time I really got angry with my sister was when my parents took my sister out for ice cream and left me to do the dishes. I was so mad, I decided to run away. My mother found me and dragged me back to the house. She was angry at me for leaving." I asked if she had told her mother how she felt. Kathie said she had told her mother that she had run away because she didn't want to be left at home when they went out. I asked if her mother had understood. Kathie said sadly, "She said she did, but," and she shook her head helplessly, "nothing changed."

At this moment a dramatic shift occurred: Kathie got up, went to Billy who was playing on the floor, swept him up in her arms, brought him back to her lap, hugged him, and started to play pat-a-cake with him, in a warm, thoughtful manner. She looked over at me, I was facing Billy's back, and she invited me to come and see Billy's face. Billy was ecstatic. This play was quite exciting for me to see. On previous visits I had suggested traditional baby games which Kathie could play with Billy. Kathie had never before picked up on this.

In this excerpt, then, we see that as Kathie reexperienced the rage toward Essie, she could turn toward her own baby and spontaneously show her affection for him. She played a game with him with full enjoyment, and we recall the words she had used in the early part of this session when she spoke of Essie, "I didn't want

to play with her. I hated to be told to play with her." As the affective pathways led back to Essie, Kathie was able to disengage Billy from the first intruder and, as if some preconscious association had taken place around "play," she gave the "no" to Essie and the "yes" to Billy. Where Kathie's mother "didn't understand" and both parents sternly prohibited the expression of anger toward Essie, the therapist understood and accepted the words, "I hated her." The play with Billy was also, then, a gift to the therapist.

This was the first time that we saw this pattern. We were to see it many times in the sessions that followed. When Kathie expressed strong feelings of anger toward her sister or sadness in remembering the rejection by her own mother, she was able to reach out to Billy and to hold him close to her. The therapist could now become more active in interpreting to Kathie the displacement of feelings from Essie to Billy.

The ghost of Essie appeared in many disguises. For weeks the therapist was puzzled by a complaint from Kathie: Billy, Kathie said, drove her to distraction when he followed her around the house. From the therapist's point of view, Billy's following of mother and touching base with her were most welcome signs of the growing attachment between Billy and his mother. Kathie found it nearly intolerable and took a dim view of the therapist's ideas on the subject.

Then, in an interview, when Billy was 8½ months old, Kathie quite unconsciously provided the vital clue. The therapist again described the session when Kathie was expressing a tirade against Essie:

"The worst thing that I hated—I was about 9 or 10—was when my sister followed me all around the house. She used to stare at me and whisper like me and repeat what I said. I used to tell my mother, but my mother said I was crazy and she could not understand what I was talking about. I couldn't stand it. I spent more and more time away from home. I wanted my mother to stop her, but my mother wouldn't." I asked her what it was that had bothered her so much. Kathie said that she didn't know, didn't care, she only hated it. She just didn't want to have anything to do with her sister at that time.

After a few moments I asked her what it was like for her when Billy followed her around the house. Kathie said, "It's entirely

different." Then she laughed. She understood. Kathie went to Billy and picked him up. She cuddled him, and put him on her lap so that he was lying on her knee, and tickled his back until Billy was laughing and giggling. He seemed delighted.

With this new insight, Kathie could now use more of the developmental and guidance information that the therapist offered. For example, regarding Billy's following her, the therapist explained that he wanted to keep her in sight at home because he was attached to her. At 8 months mother's presence was reassuring. As Billy grew, he would be able to remember her presence even if she was in another room. He would not have to follow her all the time.

Kathie's relationship to Billy was beginning to have moments of tenderness, spontaneity, and joy. She was making obvious progress in becoming a mother to Billy. She was manifestly enjoying Billy, proud of his achievements, gratified by his steady weight gain, and eager for his response to her.

However, although the teasing games with Billy receded during this period, the therapist still caught glimpses of "teasing" which concerned us. On an educational level the therapist had dealt directly with the teasing games during feeding. She pointed out that these were games which might lead to problems which Kathie would not really want to see in Billy. She spoke of the meaning that food and love had for babies as well as adults. What did these games mean to Billy? Kathie consciously made an effort to give up the teasing games, an effort which was partially successful, yet the urge to tease Billy broke through in a game, and more explicitly in withholding food from Billy when he was manifestly hungry, Kathie responding only to his most urgent cries.

Billy meanwhile was responding to his mother's efforts by sometimes showing preferential responses to his mother in significant ways, but one aberrant tendency remained. At 9 months of age he still avoided eye contact with his mother. Even in baby games with Kathie when she smiled and encouraged him, he turned his head away from her. In one sequence on tape we saw Kathie playing pat-a-cake with Billy on her lap, facing her, and the baby, though participating in the game, averted his head to avoid eye contact with his mother. Kathie, encouraged by the therapist, repeated the game until finally Billy rewarded his mother by

smiling and cooing, but still turned away from her. The therapist interpreted the smiling and vocalizing as his way of telling mother he enjoyed the game. Perhaps soon he would also give her the reciprocal gaze she so wanted as affirmation of his affection toward her. Kathie, we saw with sadness for her plight, had to work very hard to woo her baby after the many months of avoidance and neglect.

Then, when Billy was 11 months old, the meaning of the teasing games and a facet of Kathie's uncontrollable urge to inflict pain broke through in a session. The therapist summarized the critical material:

Kathie had recently returned from a visit to her own family, and was angrily recounting what had happened. Once again Kathie did the dishes while Essie disappeared from the kitchen, and once again Essie got all of mother's attention.

Kathie said, "I hate my sister. She doesn't do anything. Just like now when my mother needs her. I have hated her ever since the time I was asked to take care of her and my little cousin together. I could have been with my friends, I really didn't want to do it, but I did. After a few days my sister said to me, 'Bug off, we all hate you, we don't want you here.'"

In response to my question, "What did you do?" Kathie said, "I told my mother. She just shrugged it off." I asked, "How did you feel?" "I hated her." I said, "It really hurt, didn't it?" She replied, "Yes." Her face was red and she was very tense. I said, "It seems as though you are still angry." She said, "Yes."

Kathie continued, "I told you how I would try to get her into trouble, how I would make up stories, how I would tease her. I would tell my mother things that she would do. When she got me really mad I would shake her."

At this moment she turned to Billy who was playing on the floor, and took his arm and showed me how she would shake her sister, saying, "I would shake her like *this* and like *this*." Billy started to cry, obviously scared. I was scared for him. Kathie stopped abruptly. She was shocked and said, "Sorry Billy, I didn't mean to hurt you."

I said, "I can see how angry you feel at your sister and now I understand how you felt before." Kathie nodded. I asked her whether she sometimes got mad at Billy as she got mad at her sister, as though he were like her sister.

Kathie had an immediate response. She said, "No," in an emphatic voice and moved away from me. "I never get mad at Billy that way." Soon Kathie went over to Billy, started to play with him, got down on the floor, and for a long time held him and cuddled him.

Thus the teasing and sadistic rage toward Essie emerged from memory and could also be observed in a direct displacement toward Billy. After many interpretations, in this visit and others, of the repetition of feelings from the past in the present, Kathie's quick denial finally gave way to affirmation and insight.

The insight was very meaningful to Kathie and further freed Billy from being the target of her feelings of anger toward her sister. During the next visits we began to see a new depth in the relationship between Kathie and Billy. Teasing of Billy was significantly reduced and began to disappear. Kathie began spontaneously to reach out to Billy and, on her own, began to interact with him in such a way that both of them received great pleasure. Our observations also began to show some incidents of mutual gaze and approaches between Billy and Kathie.

KATHIE AND HER MOTHER

The competitiveness with Billy was only one of the many themes that appeared throughout the work with Kathie. There was another important theme. We had often observed her seeming indifference to Billy's cries. Many times it seemed as if she and Billy were crying together. There was no mother present in the room. With great sadness and anger Kathie would say that her mother had not understood her. Once again the therapist acknowledged that Kathie too had many needs to be heard, to be loved, and to be understood and nurtured.

The therapist asked many times what it was that Kathie most wanted her mother and perhaps the therapist to understand. Gradually her true feelings emerged. She did not want to be a mother, she had never wanted to be a mother, and she was not ready to give up her role as a child. She had in fact not really separated from her own family.

With great sadness Kathie told the therapist of the very painful

relationship she had had with her own mother. She felt that her mother was never satisfied with her, especially as a daughter. Kathie said that she had always been the family boy, loved by her father and ridiculed by her mother. As a little girl she had never played with dolls, but had always preferred to play with the neighborhood boys. As she approached puberty, she was accused by her mother of being too seductive. Nothing she did was right. With great hurt she described how her mother had said that she could never be as pretty as her older sister or as good as the younger sister. She began to go out with John, whom her mother had liked. During this time Kathie's mother had begun to enter menopause and was wishing explicitly for a grandchild. Kathie's older sister did not have any children. Kathie got pregnant and had Billy. Kathie, with hurt and anger, said that now her mother had a grandchild, but for her Billy's birth was not all that it was supposed to have been. The fantasy of renewed babyhood for Kathie never materialized. Now that Billy was born, he was the grandparents' pride, not Kathie. She was only 17 and faced with an entirely new role, that of motherhood, which she did not want.

In work with Kathie, her ambivalence toward Billy now became overt. Even as she expressed her ambivalence, we began to see progress in her relationship with Billy. As Kathie spoke of these feelings, she began to be able to respond to Billy.

Nearly every session was related to Billy's needs in one way or another. Billy was approaching 12 months of age, a time when he did not yet have words for needs. As Kathie would weep for herself and berate the mother who never heard her cries and needs, Billy oftentimes needed her.

At first she was unable to interpret Billy's cries and the therapist would talk for him. For example, many times Billy was in his playpen and wanted to get out. Kathie was unable to respond. The therapist would talk for Billy and say, "Mom, I'm trying to tell you that I want out of the playpen, but I don't have any words yet." Kathie would respond. They had many discussions about the ways in which Billy tried to communicate with her without words. When Kathie did respond, the therapist always rewarded her efforts, speaking for Billy, who was not yet able to show her that he

appreciated her efforts. The therapist might say, "Isn't it good to have a mommy who hears you and understands you? Even mommy has to be understood."

The first sign that Kathie was beginning to hear Billy and to be empathic with him was her ability to comfort him when he cried. She would pick him up in her arms, hold him closely, and pat his head. Eventually she anticipated his needs for both food and play. She took pride in his attempt to communicate and in her attempt to understand him, which the therapist encouraged and reinforced. She began to identify more strongly as Billy's mother. In fact, she started to let the therapist know that she knew Billy better, and the therapist, of course, stepped back from the role of active interpreter.

As we traced the content of these sessions "on being a mother" and the therapeutic work in this area, we could see the effects of reexperiencing, "undoing," and insight in Kathie's own ability to be a mother.

When Kathie's own cries were heard by the therapist, she began to respond to her baby's cries. When Kathie's needs were "understood" by her therapist, she began to interpret the signs of needs in her baby. When hostile feelings toward Billy could be put into words, they no longer exerted their influence in distancing Kathie from Billy; she was free to enjoy him. When the powerful ambivalence toward her own mother came into the therapeutic work, Kathie "completed" her own adolescence and became free of the "witch-mother" who impeded her own development as wife and mother.

TERMINATION OF TREATMENT AND FOLLOW-UP

The major part of our therapeutic work was achieved by the time Billy reached his first birthday. Our work continued until Billy was 18 months old, when the family moved to another community. John found new work, which brought financial security to the family.

Billy, at 1 year of age, already reflected both the changes in Kathie which were brought about in her treatment and the developmental guidance which Kathie could now use on his behalf with spontaneity and self-assuredness.

There were no residual feeding problems; Billy at 12 months and

at the follow-up (25 months) was a child who enjoyed food. He had no food idiosyncrasies or conflicts with his mother around feeding. There were no symptoms or disorders in the areas of orality or beginning autonomy. We watched carefully for signs of affective disturbances and saw none. We worried about possible residues from the sadomasochistic feeding games, which had so concerned us when Billy was 8 months old, but we could identify no sequelae in the second year behavior picture. We did observe that John still occasionally teased Billy in words or games (Kathie did not) and that Billy at these times did not participate in these games, but turned away from his father, typically moving toward other games or toys. (We wish that we could have provided more help to John in this area, but we are satisfied that Billy did not offer himself as a partner in such games.)

In his second year, Billy was a cheerful, exuberant, busy little boy, curious, eager to learn, pleased with himself. Language development was excellent.

Most important of all, Billy's attachment to his mother was secure, mutually satisfying, and demonstrably joyous. In direct observations and in a number of vignettes on videotape we saw special smiles for mother, good eye contact, seeking of mother for comfort and protection, enjoyment of games and play with mother and father, and, equally important, a steady growth in self-confidence and independence. Billy had become an endearing child to both his parents and their pride and pleasure in him came through in nearly every visit. (He was also, objectively, an endearing child as others saw him.)

The therapeutic work with Kathie succeeded in freeing her and Billy from those aspects of a conflicted childhood which were being reenacted between her and her baby. To some measure, we believe, the work also resulted in the completion of Kathie's own adolescence. The resolution of infantile conflicts between Kathie and her mother freed her to become a mother and a wife in her own rights. For not only did Kathie become a mother who enjoyed her child, but we saw many positive changes in her relationship to her husband, and the marriage gained stability.

When Billy and his parents were seen in follow-up at 25 months,

we were satisfied that he and his parents had sustained the gains of treatment. With only minimal support and guidance from the therapist during the period that followed their move from our community, both parents showed growth as young adults and had brought wisdom and good judgment to their rearing of Billy. They were justifiably proud of Billy and his achievements and spoke tenderly of his affectionate nature and his endearing ways of greeting his parents when he woke each morning.

Toilet training was proceeding smoothly. There was no sense of pressure in either Kathie or John. In Billy's play we discerned no anxieties in connection with the toilet or with cleanliness.

Recalling Kathie's earlier revulsion toward vomiting and messiness, we were interested to see that none of this had carried over to the toilet training of Billy. Since our work had not dealt with the deeper layers of this revulsion in Kathie, we wondered why the area of toilet training had not been contaminated. Then the therapist remembered that throughout the early critical period of the treatment, she had observed many diaperings of Billy, but at no time had Kathie shown revulsion toward the baby's feces or cleaning the anal region. It was, then, specifically an oral revulsion on Kathie's part, in which food and vomit may have had anal determinants, but were curiously not manifest in connection with anal functions.

One vignette from our last records of Billy and his family is cherished by all of us. The therapist had made a visit to the new home of the Douglas's when Billy was 20 months old. Billy remembered her well and was very much a delighted child seeing an old friend. At one point he left the room and returned with a handful of Chinese noodles which he pressed in the therapist's hand. Kathie said, "He likes you. He always does this. He likes to share his favorite foods with people he likes."

BIBLIOGRAPHY

- BARBERO, G. J. & SHAHEEN, E. (1967), Environmental Failure to Thrive. *J. Pediat.*,

10/15/80

FR: Kelly

Per Phone conversation with SF, title chosen for Peds.
Grand Rounds is "Psychological Questions in Failure to
Thrive: A Perspective from Infant Mental Health."
Above was communicated by phone to Dr. Peter Davis'
secretary.

SFGH PEDIATRIC CONFERENCE SCHEDULE FOR THE MONTH OF NOVEMBER 1980

PEDIATRIC GRAND ROUNDS
TUESDAY, NOV. 4, 8:30 A.M.
PATHOLOGY AUDITORIUM

Wed., Nov. 5, 8:30 A.M.
Room 6A

Thurs., Nov. 6, 11:00 A.M.
X-Ray Conference Room

Fri., Nov. 7, 8:30 A.M.
Room 6A

PEDIATRIC GRAND ROUNDS
TUESDAY, NOV. 11, 8:30 A.M.
PATHOLOGY AUDITORIUM

Wed., Nov. 12, 8:30 A.M.
Room 6A

Thurs., Nov. 13, 11:00 A.M.
X-Ray Conference Room

Fri., Nov. 14, 8:30 A.M.
Room 6A

PEDIATRIC GRAND ROUNDS
TUESDAY, NOV. 18, 8:30 A.M.
PATHOLOGY AUDITORIUM

Wed., Nov. 19, 8:30 A.M.
Room 6A

Thurs., Nov. 20, 11:00 A.M.
X-Ray Conference Room

Fri., Nov. 21, 8:30 A.M.
Room 6A

PEDIATRIC GRAND ROUNDS
TUESDAY, NOV. 25, 8:30 A.M.
PATHOLOGY AUDITORIUM

Wed., Nov. 26, 8:30 A.M.
Room 6A

Thurs., Nov. 27
Fri., Nov. 28

CYSTICERCOSIS AND OTHER
CEREBRAL PARASITES
Donald Heyneman, M.D.

Social Service Conference

Radiology Conference

Immunizations in Childhood
Moses Grossman, M.D.

TUBERCULOSIS - Moses Grossman, M.D.
TUBERCULOSIS SKIN TESTS AND ANERGY -
Bob Levin, M.D.

Diarrhea and Malabsorption
Jay Perman, M.D.

Radiology Conference

Pharmacology of Dilantin and
Phenobarbitol - Bob Levin, Pharm.D.

NEPHROTIC SYNDROME
Tony Portale, M.D.
HYPERCOAGULATION IN NEPHROTIC
SYNDROME - Marion Koerper, M.D.

Allergy Seminar: The Nose and Eye
in Allergy - Mark Perisol, M.D.

Radiology Conference

Adolescent Conference

PSYCHIATRIC QUESTIONS IN FAILURE TO
THRIVE; A PROSPECTIVE FROM INFANT
MENTAL HEALTH - Prof.S.Fraiberg

Morbidity and Mortality Conference
Neonatal Death

Thanksgiving



OCT 16 1980

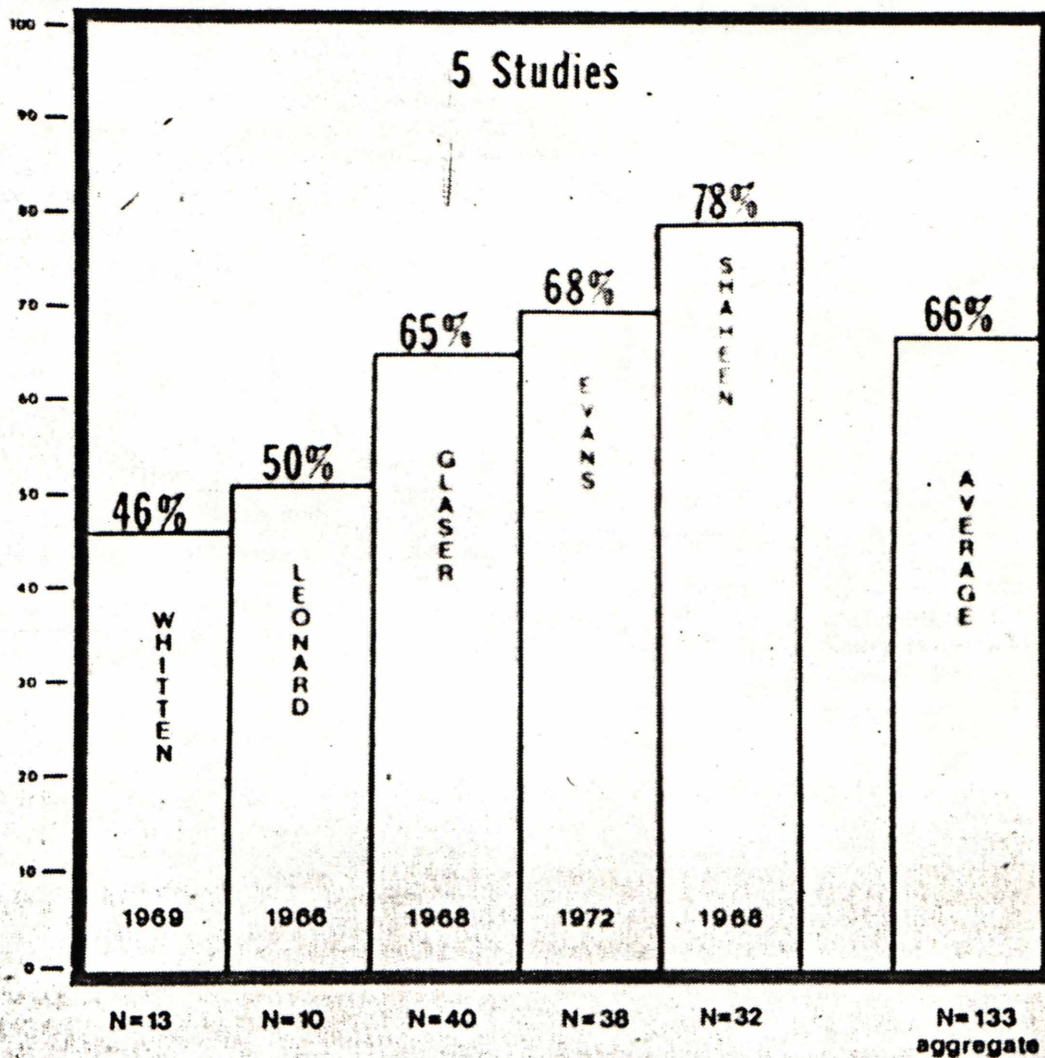
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Waltman .

" Billy " - Jewish curves -
+ often has . hfs .

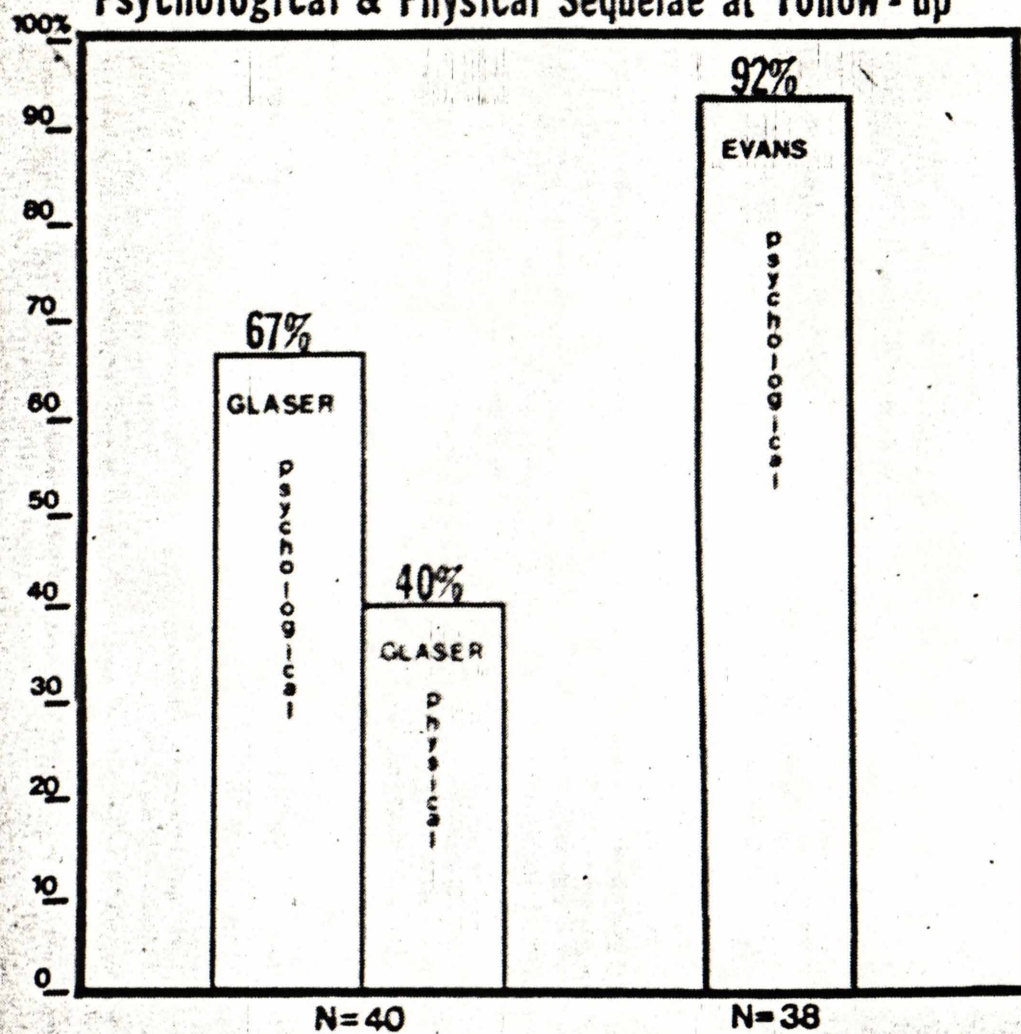
Side I

TABLE I
% of Outcome $\geq 3\%$ at Follow-up



Slide II

TABLE II
Psychological & Physical Sequelae at Follow-up



Grand Round.

TAPE RECON

Non-organic FTT

" In the Atmos

I Tuti. Psy. questions in Failure to Thrive:
a perspective from infant mental health.

Infant-mental health a new field - less
than a decade - collar of psychiatry & pediatrics.
In the case I, today of I speak about questions.
we are to look them as "questions". ^{They} of
answers with comes as only when we put the
clinical questions into the form of research questions,
and conduct ~~these~~ studies through
the collaboration of pediatrics & psychiatry.

~~making what~~

^{current}

Our practice in the diagnosis & treatment of

non-organic FTT is critically based upon

~~history which is now the early finding~~

the maternal deprivation studies in psychiatry

about 40 years ago. ~~These are the findings~~

~~in these studies. There were studies of~~

~~malnourished depressed infant in institution~~

~~severe deprivation. These findings were generalized~~

a collaboration
of ped. &
psyche.

the over
of institutional

In the past 40 years

we have learned a great deal ^{more} about the effects of infant-mother relationship. Our diagnostic criteria ~~are highly refined~~ for "maternal deprivation" have been refined. But the translation of these findings into the diagnosis & treatment of FTT lags far behind. Thus,

There, then, is my first question from the perspective of inf. m.H

(1) Does the present state of our diagnosis ^{management & treatment} reflect ~~the~~ advances in inf. development research & exp-parental interactions which have taken place in the past 40 years?

Then I propose to ^{follow my} ask another group of questions

In this paper I propose to ~~ask~~ ^{look at a number of} address the questions which have emerged ^{in my} from experience in the course of a work at the University of Michigan. (see notes rec at SF & H).

- extrapolation
but few good
empirical studies.
1. origin of the maternal deprivation syndrome.
 2. hospital ~~deprivation~~ ^{hospital} practice in diagnosis & treatment which emerged.
 3. FTT Outcome Studies.
"not good outcome" - parents unreliable.

3

Summary

1. Meque - Mat. Dep. Syndrome - Insulation
— this nearly total deprivation - microsmes.

2. Applications - diagnoses of exclusion -
if - De neuro - Substitute ms - can feed by
+ gains - the mother body is center to his ms -
neglect.

3. Outcome studies -

p. 4

4. Unpsychological questions -

Include

Observation - of ms & body Taggart
Observation of muscles

Self observation

* Great

4

4. The psychosocial question -
feelings a. what does the exp. M. H. team do
b. what is the evidence for
maternal deprivation, "rejection" etc.

c. what do we see.

d. how can

a. what are implications for treatment.

(2) 24 5

their parents. The insights gained have been translated into a treatment program which has brought mainly favorable outcomes for these babies and their families.

In our presentation today we will begin with a brief survey of the outcome literature in failure to thrive, then move to an examination of our own experience through five phases in the treatment program. We will conclude with a video tape presentation of one baby and her mother who fairly represent our sample.

A SURVEY OF OUTCOME STUDIES

The literature on failure to thrive is familiar to this audience and we will do no more than summarize the major reports and areas of consensus.

Among several hospital populations studied, 1 - 5 percent of admissions to children's units were for failure to thrive of undifferentiated etiology. Up to 50 percent of these infants and children revealed no organic etiology after extensive and intensive study. The largest number of these have been identified as children who also suffer gross maternal deprivation.

The typical course of hospital treatment is one in which the infant is provided with good nutrition and substitute mother care through nursing, which results in normal weight gains during the period of hospitalization. Although many sustain these weight gains, a substantial

number are eventually readmitted, or admitted elsewhere, under the same diagnoses.

WEIGHT:

Slide
- INSERT TABLE I -

1 on => Five follow-up studies report on the weight status of children from 3 to 40 months post-discharge. Using the Boston Anthropomorphic Scales and a weight adequacy criterion "at or above the third percentile," the outcomes, as you can see, range from 46 to 78 percent who achieved weight adequacy.

PSYCHOLOGICAL:

Slide
INSERT TABLE II

2 on => Since we are following a psychiatric inquiry into outcome reports of FTT we are sobered by the reports of the residual effects of FTT on later psychological functioning.

From this table we understand that whether or not the FTT baby attains weight adequacy, the effects of malnutrition and emotional deprivation can be discerned in nearly all of these children upon follow-up. Glaser reports that 67 percent of his FTT population showed persistent and serious problems in feeding, behavior disorders, significant school difficulties, and mental retardation, while 40 percent show physical stigmata associated with early nutritional and emotional deprivation. Evans reports that over 90 percent of her population showed persistent problems in the same areas cited by Glaser, also listing "strong evidence of child abuse" for several children.

The parents of FTT children have been described in a

number of studies as "hard to reach," "uncooperative," "hostile," and sometimes manifestly rejecting of their child. Maternal depression in the range moderate to severe has been reported in several studies. The socio-economic status of the families covers a broad spectrum, but poverty is over-represented.

INTERVENTIONS:

With these weight and psychological statistics the social and psychological services provided these babies and their families interest us also. During hospitalization these range from educational guidance through nursing to intensive casework intervention. After discharge, however, the continuity of focus on the baby and his illness is usually broken. Most of these families are referred to agencies in the community ill-equipped to deal with the formidable psychological and physical problems in the infant and severe psychosocial problems in the parents, and many discontinue agency contacts after the initial referral period.

In our conventional language in ~~In this respect our attention~~ FTT reporting we say that the good work of the hospital and its intensive care is undone by the parents after the baby leaves the hospital. We would suggest that the good work of the hospital can be undone by the poverty of infant mental health resources available to these infants and their families in the community. ~~The many of these just~~

In this respect our attention is arrested by Shaheen and

~~how and~~
~~seem to be~~
~~undulate~~

Barbero's study where casework treatment, ~~and at times, extension~~ *per - r per diary* ✓
~~of hospitalization in order to extend treatment~~, maintains the
continuity of focus on the infant and is associated with
improved outcomes.

8

(5)

ampers

need not, and at times, extension of hospitalization
maintains the

Barbero's study where ~~intensive~~ casework ~~and~~ continuity of focus on the infant through hospitalization and post-discharge ~~and~~ is associated with improved outcomes.

AN INTENSIVE DIAGNOSTIC AND TREATMENT PROGRAM IN A
PSYCHIATRIC UNIT

U of M

In our own program at the Child Development Project we ^{are} prepared to offer intensive treatment, up to the capacity of our small staff, for all cases in which an infant's

..7

impaired development required the specialized intervention of a psychiatric unit. We do not pre-select families for intensive treatment on the basis of prognosis or parental cooperation. We ^{are} willing to take into treatment babies and families with severe disorders. In all cases our failure to thrive babies and their families have required intensive treatment.

Our FTT babies 10% of children
diagnosed
C

As a mental health unit we have ^{had} two main objectives in our treatment program for FTT babies: ^{First} (1) We must bring the baby to nutritional adequacy and; ^{Secondly} (2) We must bring the baby to psychological adequacy.

In our presentation today we will report on 11 babies who were referred to us as FTT.

53%
usually most severe
actions - had numerous complications

4. The psychiatric questions.

Mo. of birth + parents - in hospital - at home - 5-7 sessions assessment
 K no instruments - General Mo. - then a Mo. of persons.

The ^{initial} impact of a storming baby on the

psychiatric process is exactly like that upon a pet planted profoundly disturbing the

same for psychiatric as lesions. I will

make a great point of this because it is very

important.

Again at the mother who is starting her baby - ~~Woman - I can stand it. I don't know of Jean's m.~~ ¹⁹⁴² Picture - video of Billy - 5 minutes - creeping towards her brother. Show. Oh. my god, no! I will wait to resume the bal. She has home needs as. We drink the mother on the screen. ^{at first} We hear house - peeing bottle on the floor. We hear.

he say. "The idea is better that way". If I were to
take an audience here at this point ^{in the video} the picture

that is before in our mind would be something

like this. "A witch-mother" - a monster

mother " It rescues the baby from his monster.

mother is the ^{next} most urgent thought. Pictures

appear in our heads.

In the next scene we see the mother. Karl

17 years old. School girl. T-shirt. She is

invited to look the baby - in our room - The

camera focuses to her face. Holding the baby

simply in her arms - mo. & baby never

look at each other.

The picture of the mother-mother in our head
now stands side-by-side with the picture on
the screen. If we allow the picture of
mother-mother to be super-imposed upon the
picture of the screen, we will see a teen-age
mother-mother. In this case we have not made
a diagnosis, of course, but it is terrible hard
to get the mother-mother out of the picture.
~~like~~

The problem is just

It doesn't matter whether one is a pediatrician
or a nurse or a psychologist or a scholar or a
social worker, we all struggle with the same
problem.

Whenever in the ~~audience~~ ^{room} we have
we can put the mother-mother to one side and
look at the teen-age girl mother on the screen.
we can see something else. ^{nothing there} The girl mother
is a child, herself. Then we look - Since we
are watching her for & listening to her voice.
Something else registers. This is a ~~very~~
seriously depressed teen-age girl. Now we
~~begin to feel~~ we move & what we see. The
the camera moves back to the boy. & then
that we are caught by the terrible implication

of interest in her. A teenage depressed girl. But she
is ~~the~~ a mother - and the mother of an FTT
baby.

~~Case Study~~

~~2~~

How we have already moved from self-observ-
tion to observation of the mother and baby. The
mother labeled rejecting mother is now seen as
a depressed mother.

What she does see -

Attachment criteria

at

Developmental -

Bayley.

Attachment criteria

Smile.

Gaze

~~to~~ motor

usual.

distress

all negative -

on my assessment profile - the child is
more severely impaired.

(usually a mixed picture)
also ~~having~~ Stereotypic order.
~~not not at all~~

1/2 again -

assess contact & how - not just feeding.

Neotoma alternative - placement -
work in the home -

In the home - 2 tasks -

Two tasks -

nutritional adequacy.

psychological adequacy.

14

Present chair

1/2 - "cooperative" ? no real,
but forgotten,

th. The mother is needy as the child
psychol. human.

Intuition -

th
Immense &

2 G. of cereb -

1st. ~~ignores~~ ^{ignores} ~~beating~~ !

longest face.

Psyde.

psychology in the child

Combined - dev. Judaism.
& psych.

mo - depression.

rage - I expect him the worst part of the
house.

around Bill - afraid he rage cannot
break through.

desire & feeling more towards baby.

at 11 months - psycho. adequacy.

1 year more of function work.

16.

~~Findings~~

Findings - 11 cases.

Only 1 case in 11 - in which the classical picture of FTT syndrome was seen.

Schizophrenia

paranoid type.

Recommended treatment.

Insulin.

at intake depression - 8 of 11

Unhappy mood 1

50% ~~ten~~ age

ten age. 6/11

Amorose + ignorance.

the mothers in our group showed symptoms of a severe thought disorder and her husband was manifestly paranoid and dangerous. For the last, Harry's mother, the diagnostic picture is unclear at the close of assessment.

The mental health clinic is advantaged from the start when it can give the disease its proper name. Nobody loves a "rejecting mother". When the "rejecting mother" becomes a depressed mother or a psychotic mother we can summon our resources.

Other Factors:

The picture, thus far, grows in complexity and ambiguity. Let us add to the list of ambiguities. In the sample which includes seven primiparous mothers we also had our share of innocence and ignorance of even commonplace practices in feeding and caring for babies. There was the teenage mother whose baby vomited after every meal. In home visits we found out why. She burped the baby after each meal by tilting him over the sink so that he wouldn't spit up on her! Another mother whose baby couldn't keep her food down demonstrated her methods of feeding to us. We saw that she held the baby at a declined angle of 30 degrees, presumably so that the bottle would drain into her nicely. There were mothers who literally did not know how much food a baby needed,

or what kinds of food. The teenage mother who liked nibble foods and Kool-Aid, fed her baby her favorite foods. The teenage mother who found pureed foods "yucky" declined to give her baby pureed foods. Then, since nearly all of

~~Then, since nearly all of~~
our mothers had no stable family traditions in infant rearing, the practice of storing the baby with neighbors, relatives, itinerant baby-sitters and community day care centers seemed consonant with a life style in their community. The meaning of human attachments to a baby had never entered their experience until our own work introduced this novel idea. To the credit of these parents it must be said that all but one of our families could understand these ideas and make use of them. The one family that could not I have earlier cited; the mother with the thought disorder and the paranoid father.

Finally, since we are dealing with the full gamut of environmental factors which impinge upon the FTT baby, we must give weight to poverty itself. In all of these homes there was hunger for the adults as well as the children. Thus, the AFDC highest food allowance nation wide gives \$1.32 per day per person in 1977. This includes food stamp values. It is possible that a nutritionist who understands food values and is an expert shopper could provide nutritional adequacy for adults and children on this allowance. Most of us could not. Our young families in poverty, unschooled in nutrition, often, we suspect, unable to cope with arithmetic in the supermarket, were suffering with

chronic hunger. We saw teenage parents with teenage appetites competing with their own babies for the available food which, as often as not, might be soft drinks and sugared snack food. We will never forget the 17 year old mother of a starving baby who said, "But if we give him everything he wants, he'll eat us out of house and home!"

Attitudes Toward Treatment:

INSERT TABLE VI

Finally, we must report at Interval 2 that in the course of the first assessment period, five-seven sessions, very important changes had taken place in the parental attitudes toward us and our offer of treatment.

~~TABLE VI~~

Slide 7

In Table VI we match parental attitudes as scored on the first visit with parental attitudes at the close of the initial assessment period. In First Visit with an N of 10, only two families are rated by us as "positive" toward our offer of assessment and possible treatment. Eight families were either "negative" or "ambivalent." At Interval 2, within five-seven sessions, seven families are rated by us as "positive" and three are "negative" or "ambivalent". This is almost a complete reversal of positive and negative ratings. It means, very simply, that we can agree that most parents of FTT babies are initially hostile and negative, but that these attitudes are reversible when a psychiatric team can deal with parental feelings of anger and distrust and engage the parents in collaboration on behalf of their baby.

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4. TREATMENT

We will describe in briefest summary our treatment methods.

Our therapeutic and educational work is mainly carried out through home visits, once or twice a week. During emergency periods there may be daily visits.

The therapist may be a clinical psychologist, a social worker, a psychiatrist, a pediatric nurse. Regardless of differences in our training and discipline, when we are therapists for the baby and his family we all work in the same ways. We do not follow the traditional psychiatric team approach which divides the child and his family between two or more specialists. However, when we serve as consultants to each other, each of us brings his area of expertness to the consultation.

Psychotherapy:

Our treatment methods are highly individualized for each family, as they must be when we consider the diversity of the problems presented. In the description that follows we will attempt to present the general methods and principles of treatment which are common to all cases, and specifically for this discussion, FTT.

The baby, of course, is at the center of treatment. Both he and his parents are our patients. He is present during each home session (if he is not taking an unexpected nap) and typically he is the focus of our observations and

our discussions with the parents. Since the baby is the patient who can't talk, we become his spokesmen in a certain sense.

But his parents are our patients, too. And, in a typical session we will see discussion between the therapist and parents move easily and naturally between the baby and his needs, and his problems, and the parents and their needs and their problems, especially those that have bearing upon the baby.

. 219 22

As the talk moves back and forth between the present and the parental past we begin to understand the connections and circumstances which have brought the baby into the center of conflict for his parents. Here we will also find our entry into the therapeutic work which will eventually remove him from the focus of those conflicts.

Treatment - Depression - how the mother in conflict
We may meet a forlorn and crying baby, named Billy,

and a forlorn and crying teenage mother who cannot hear and respond to her baby's cries. But if we can listen to the crying mother and her story, offering words of comfort, understanding and insight, we may witness one of the customary miracles of baby work. The mother, whose own cries have just been heard and sympathetically understood, will move toward her baby, pick him up, hold him and murmur comforting words to him.

There may be another baby, named Trudy, in another room, ^{lonely} lying in a heap of rags, unfed, staring with glazed eyes, and the teenage mother, sitting on a soiled mattress is telling her own story. Gwen, the mother, is a girl who was without a history until she was 2½. She was found abandoned and starving on the streets of an Asian city, like tens of thousands of children in war time, and was taken to an orphanage. Later, she was adopted by American parents. Now there are two abandoned children in this living room. The past is repeated in the present. The therapist must find a bridge between the helplessness and terror of one baby (who

is now the mother) and her own baby, now one of our patients. And when the bridge is made, the once abandoned mother begins to move protectively toward her baby and will no longer let her baby starve...

In these vignettes we can see that one part of our method is based on traditional psychotherapy. But something new has been added. It is the inclusion of the baby in the treatment and in the focus of treatment. There also has been a shift in locale, from the clinic office to a livingroom or kitchen. (We call this psychotherapy in the kitchen.) The largest number of our patients would never be persuaded to come to conventional psychotherapy sessions in a clinic. But we are mainly welcome in their homes.

The home visit offers large advantages in treatment, but we should also include in these advantages the opportunity to observe a baby and his family in their own home. We need the largest and most diverse natural circumstances to make a fair appraisal of the baby, his parents and their modes of interaction. Only the home can give us this.

GUIDANCE AND EDUCATION:

Another part of our methods may be called "guidance and education." Since we are unconventional anyway in our

psychotherapy we do not adhere to the convention that the therapist should deal only with psychic conflicts and leave guidance and education to another profession. (As a matter of fact, child psychoanalysts have always considered themselves educators as well as therapists.)

If Gwen, the teenage girl who was abandoned in childhood, can now move empathically toward her baby, she will not miraculously and intuitively know how to feed a baby or take care of a baby. And Gwen, who lost a mother herself during her early years, will not make the discovery by herself that her baby must learn to love, to trust, and to form her permanent bonds with the human community through the love of her mother.

Gwen's therapist, like all therapists on our staff, is as knowledgeable about nutritional needs of babies and developmental psychology as she is about psychotherapy. In a tactful, non didactic way, the therapist builds in a fund of information about babies, and specifically, Gwen's baby, in the course of these home sessions. This baby is starving, but Gwen does not have even the most elementary knowledge of a baby's diet or techniques of feeding a baby. The therapist uses the trusting relationship she has built with Gwen to build in this education. And the baby begins to gain weight steadily. Gwen, who cannot quite believe that love begins in infancy, begins to learn to recognize and value the signs of preference and love which

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her baby is ready to give her. She needs her therapist to show her that her baby values her mother above all other persons and to give monumental importance to that love.

What else does the therapist do?

Support:

If the family has never known a doctor except in a hospital emergency room (as is the case for many of our families), we can arrange for excellent pediatric care for any baby in our program regardless of income. Will the family then use the excellent care available to them? That may need our help, too. Most of our families are quite literally afraid of doctors and of hospitals. We offer to accompany our families to the doctor's office if the family would like us to and, in nearly every case, the offer is gratefully accepted. After several such visits most of our families will no longer need us as intermediaries. Our collaborating pediatricians and nurses have their own good ways of earning trust if their patients will give them half a chance.

The therapist in our program may need to represent his patients and their "rights with the bureaucracy that administers public assistance. We do not consider it an extravagant use of professional time for a psychologist or psychiatric social worker to spend a morning tracking down a lost relief check, or to appear in private chambers with a board of public assistance supervisors, to argue for a 50¢ per day

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food supplement for a baby who is sharing the hunger of a large family. Our psychiatric training may even be considered an advantage in these exercises. We nearly always win.

All of this and much more will transpire in the living room, and in the offices and clinics in our community. For every FTT baby in our program, we consider that the first two to four months of treatment constitute an emergency period. Our goal is to bring every baby to weight adequacy as rapidly as possible. A starving baby cannot wait for his parents to resolve their personal conflicts, but it is this support and guidance, united with psychotherapy which will help the baby begin to thrive. We will continue to work with the baby and his parents toward our long-term objectives--providing psychological help for the parents and achieving psychological adequacy for the baby.

5. RESULTS OF TREATMENT

All eight families in the treatment group sustained treatment for a period six months to 2 1/2 years. This includes..sadly..the one baby mentioned earlier whose diagnosis changed during the extended period that we worked with the family. Harry was the only baby in the treatment group who failed to reach weight adequacy, but the close work with Harry and his family permitted our medical staff and the baby's own pediatrician to examine and re-examine the diagnostic issues. There was finally a consensus

Farlow & Krum
Bibliograph

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REFERENCES

- Adelson, E. & Fraiberg, S. (1977), An abandoned mother, an abandoned baby. Bull. Menninger Clinic, 41(2): 162-180.
- Barbero, G. & Shaheen, E. (1967), Environmental failure to thrive: a clinical view. J. Ped., 71(5):639-644.
- Cherniss, D., Pawl, J. & Fraiberg, S. Nina: developmental guidance and supportive treatment for a failure to thrive infant and her adolescent mother. In: Clinical Studies in Infant Mental Health: The First Year of Life, Fraiberg, S. & Fraiberg, L. (In press).
- Coleman, R. & Provence, S. (1957), Environmental retardation (hospitalism) in infants living in families. J. Ped., 19:285-292.
- Evans, S., Reinhart, J. & Succop, R. (1972), Failure to thrive: a study of 45 children and their families. J. Am. Acad. Child Psychiat., 11(3):440-457.
- Fraiberg, S., Adelson, E. & Shapiro, V. (1975), Ghosts in the nursery: a psychoanalytic approach to the problems of impaired infant-mother relationships. J. Am. Acad. Child Psychiat., 14(3):387-421.
- Glaser, H., Heagarty, M., Bullard, D., & Pivchik, E. (1968), Physical and psychological development of children with early failure to thrive. J. Ped., 73(5):690-698.

- Hannaway, P. (1970), Failure to thrive: a study of 100 infants and children. Clin. Ped., 9(2):96-99.
- Leonard, M., Rhymes, J. & Solnit, A. (1966), Failure to thrive in infants: a family problem. Amer. J. Dis. Child, 111:600-612.
- Riley, R., Landwirth, J., Kaplan, S. & Collipp, P. (1968), Failure to thrive: an analysis of 83 cases. Calif. Medicine, 108(1):32-38.
- Shaheen, E., Alexander, D., Truskowsky, M. & Barbero, G. (1968), Failure to thrive--a retrospective profile. Clin. Ped. 7(5):255-261.
- Shapiro, V., Fraiberg, S. & Adelson, E. (1976), Infant-parent psychotherapy on behalf of a child in a critical nutritional state. PSC, 31:461-491.
- Whitten, C., Pettit, M. & Fischhoff, J. (1969), Evidence that growth failure from maternal deprivation is secondary to underfeeding. J. Am. Med. Assoc. 209:1675-1682.

*ERRORS IN DIAGNOSIS

Evans reports that on follow-up evaluation 5 of 45 (or 11%) "developed questionable organic difficulties which might have explained the original growth failure." In another study (not reported in this paper because of incompatibility in growth charts) Riley reports that 10 of 83 (or 12%) fall into an "Idiopathic Group." That is: "No satisfactory reason for growth retardation was discovered in these children, despite careful study during hospitalization." Other studies in the outcome literature on FTT do not report subsequent changes in physical diagnosis at follow-up or groups with undefined or questionable etiology. However, Evans' and Riley's data suggest that for a significant proportion of the FTT population intensive medical study may either be unrevealing (Riley) or subsequent medical study at follow-up may change the diagnostic picture in favor of organic etiology (Evans).

In the CDP population, periodic review of the diagnostic picture led not only to changes in physical diagnoses - 2 of 10 (or 20%) originally diagnosed as non-organic FTT were subsequently found to have organic difficulties which accounted for growth failure - but also to changes in the psychiatric diagnosis. 2 of 10 (or 20%) non-organic FTT referred to us with the diagnosis "maternal deprivation" were found not to be maternally deprived but to be suffering from other causes.

*CHANGES IN DIAGNOSTIC APPROACH

Three studies (Barbero and Shaheen, Hannaway, Glaser) raise questions about hospital diagnostic procedures for FTT. Because of his generally poor physical condition on admission and the scarcity of specific physical findings, the child is typically subjected to a multisystemic diagnostic approach which has iatrogenic effects. Strenuous laboratory and radiological examinations often result in further deterioration of the child's clinical status - i.e. further weight loss.

These authors, noting that change in the child's environment and the empiric use of some form of therapy often bring weight gains and clinical improvement, suggest changes in diagnosis for FTT. The traditional multisystemic approach should be abandoned: unless there are specific clinical symptoms or abnormalities noted on physical examination a period of observation prior to investigative or therapeutic procedures is an important, parsimonious and inexpensive diagnostic tool in its own right.

10/31/78

Boston Meeting

Tufts Medical Center

Reading copy.

thus
In my presentation ~~today~~ I will address the issues of epidemiology and prevention through a report on a group of "failure to thrive" infants and their families who received intensive outpatient treatment in our program at the Child Development Project, University of Michigan.

The assumptions which underly the diagnosis "failure to thrive" are that in the absence of an organic etiology, growth failure must be seen as caused by severe maternal and emotional deprivation.

It is regarded legally in our state to be a form of child neglect

10/24/77
Cleveland copy
SIF 8

63
12
I need more of these

2

INTERVENTION AND FAILURE TO THRIVE: A PSYCHIATRIC
OUTPATIENT TREATMENT PROGRAM

Selma Fraiberg and John Bennett

Among the central issues of this conference is that of early identification and treatment of infants who show the signs of grave emotional impairment due to maternal deprivation. One such group which has been singled out for special attention is growth failure resulting from maternal neglect or incapacity. The reports in our literature are sobering. Follow up studies of babies hospitalized and diagnosed as "non-organic failure to thrive" reveal that over 34% do not attain weight adequacy in the extended period post-discharge. Equally ominous are the reports that show that whether or not the FTT baby reaches weight adequacy, 80% of children who have been diagnosed as non-organic FTT show residual effects of nutritional poverty and emotional deprivation in serious to severe personality problems, learning disorders, and mental retardation.

all sobering. They reveal that on the average

of these babies

Glaser et al

We have been fortunate in our program at the Child Development Project, University of Michigan to have the collaboration of pediatricians and nurses in our hospital and in our community in providing an outpatient psychiatric service for babies who show the early signs of severe emotional deprivation. Our own staff of infant specialists in pediatrics, psychiatry, clinical psychology and social work

Barker + Shulman 1967, Evans et al 1972, et al
Glaser et al 1968, Leonard et al 1966, Rulenz 1968,
Whitton et al 1969

3

6.2

can provide intensive treatment in a home based program for the most severely imperilled babies who come to us. This includes, of course, a number of FTT babies and their families. There is no fee for our services. Our program is supported by NIMH and the Grant Foundation. The only requirement for eligibility is a baby in trouble and residence in Washtenaw County.

Our own experience with FTT babies and their families encourages us to present our findings today. The collaborative pediatric-psychiatric approach has enlarged our understanding of the complex issues that underly this form of growth failure in infants and disabilities in their parents, and the insights gained have been translated into a treatment program which has brought mainly favorable outcomes for the babies and their families.

In our presentation today we will begin with a brief survey of the outcome literature in failure to thrive, then move to an examination of our own experience through five phases in the treatment program. We will conclude with a videotape presentation of one baby and her mother, who fairly represent our sample.

A SURVEY OF OUTCOME STUDIES

The literature on failure to thrive is familiar to this audience and we will do no more than summarize the major reports and areas of consensus.

The format which we have chosen for presentation examines our findings at five intervals in the process of diagnosis and treatment. It seemed to us the fairest way of presenting our own experience, since as you will see, the complexities and ambiguities emerge through intimate knowledge of the families and their babies. The picture changes for us at each interval.

The five intervals are: (1) Intake; (2) Close of initial assessment period; (3) Decision making at staffing; (4) Treatment; (5) Results of treatment.

Rediff

3 on 7

Table VII = Slide 3

Because there are changes and attrition in our sample during the course of assessment and treatment, let me summarize the figures beforehand. We will begin at Intake with an N of 11. 2 of these will drop out because of subsequent findings of organic etiology, leaving an N of 9. 1 will be recommended for urgent placement, leaving 8. And 1 family will refuse treatment, leaving a final N of 7, post treatment. We will summarize these figures again at the end of the paper.

3 on 7

1. INTAKE

The first interval for reporting will be "Intake".
When the referral phone call comes to us we may know little

As the basis of referral

more about the baby and his family than the diagnosis "failure to thrive; no organic basis for growth failure; child believed to be suffering from maternal and emotional deprivation.." Between 1972 and 1976, 11 babies and their families (~~10 of 11 in a 1 1/2 year period~~) were referred to us as failure to thrive with the request for study and possible treatment. *10 of these 11 were referred in a 1 1/2 year period.*

We accepted every case referred to us within the geographic area of Washtenaw County. The 11 children ranged in age from 4 to 30 months. Ten of the 11 children had been admitted to the hospital with weights below the 3rd percentile. One child, Billy, was referred at five months of age when an alert resident read the ominous signs of growth failure and maternal deprivation in a child who had not yet dropped below the 3rd percentile. We have included him in our sample for good reasons. Early identification and treatment made hospitalization unnecessary.

We will also know one more important fact at the time of the referral phone call. The majority of the families consulted about referral to us did not want "help" from us or anyone else. Typically, they were hostile and distrustful. In six of our cases only the most extraordinary efforts on the part of our staff made it possible to meet the family for the first time. Mainly the family saw "no problem" or blamed the hospital for not finding the cause of the baby's "feeding problem".

In these respects our parents of failure to thrive babies do not differ from a large number of parents who come to us with grave disorders in their babies and disorder in their personal lives. We read the initial reactions as fear. It is our job as a psychiatric unit to understand that fear, to dissolve the image of the dangerous and omnipotent doctor, or shrink, or do-gooder, and to bring about a collaboration between the parents and ourselves on behalf of their baby and for themselves.

Our initial assessment period, as we described earlier, will typically involve five to seven sessions, mainly in the home with the baby present, and one of these sessions will be a developmental assessment at our office using the Bayley Scales. This extended assessment gives us a broad range of observations in which the capabilities of the baby and his parents, as well as their incapacities, can be put into a fair perspective. A primary therapist is assigned to the family at the point of intake, so that if assessment leads to the recommendation of treatment there will be continuity from the start. The assessment therapist is teamed with one other therapist on staff who will do the developmental testing, and a supervisor-consultant is assigned who coordinates findings. A support team, consisting of the Project's own pediatrician, pediatric nurse ~~practitioner~~ and other consultants among us provides expertness in specialized areas.

During the assessment we consider that we have objectives which go beyond the gathering of information. We must win the confidence and trust of parents who are typically distrustful and suspicious of "helping people" and more often are openly hostile. At each visit we deal sympathetically with the distrust and often outspoken anger of parents and through our own consistent concern with the parents' feelings and our concern for the endangered baby we are usually able to enlist the parents' collaboration with us on behalf of their child.

In the case of FTT babies we are sympathetic with the plight of the parents, we are non-judgmental, and we do not become involved in the argument between the parent and the hospital. If the parent feels that the doctors have failed them because "they didn't find anything wrong (medically)", we will say with fairness and accuracy that it is terribly frightening to parents not to know what is wrong with their baby and that we and the doctors will now work together with the family to try to understand what is causing the problem. We will give them all the help we can and when we begin to understand the problem we will share our understanding.

In the case of the parent who has been warned of court action by the hospital we are prepared for the parent to see us as another arm of the court and we must deal fairly with their fears of us. Since we cannot know, at the start of the assessment, whether in fact we may support neglect charges after assessment, we deal honestly with parental concerns that the baby may be taken from them. We explain that the court wants parents to have every chance to help their baby and to keep families together. We are the people who help parents and babies so that they can stay together. We are not part of the court. However, if we and the families cannot help the baby, then the court will be concerned. In fairness we can say that we have helped many families and we want to do everything we can to help this family.

11

In this way, a number of families in our caseload, not only FTT, have come to see us as decent and trustworthy people, ^{and} that's all we need for a start.

2. THE SECOND INTERVAL: CLOSE OF THE ASSESSMENT PERIOD

At the close of our assessment period, typically five to seven sessions, our picture of the 11 babies and their families has been enlarged and the complexities and ambiguities of the label "failure to thrive" begin to emerge.

First, we must report that one baby (Brenda) must be dropped from the sample during the assessment period because the diagnosis is in dispute. In the opinion of our own pediatrician the baby's severe and protracted diarrhea required more extensive lab work and he, himself, was unwilling to make a diagnosis on the basis of the medical evidence. The parents, themselves, requested another study

at an out of state hospital. We have no further medical reports but the parents reported satisfaction with the study and recommendations. As a disputed diagnosis we have chosen not to include this case in the sample we report.

There is one other baby in our sample whose diagnosis will be in dispute. But we don't know that for several months. Since we are reporting the diagnostic picture as it develops in the course of study we will keep Harry in the sample at this time.

INSERT TABLE III - Slide 4

With an N of 10 now, all fairly diagnosed to the best of our knowledge, we should now examine the characteristics of our group.

~~TABLE III~~

The birth weights of all babies were appropriate for gestational age and above the third percentile. The distribution by sex is balanced. Seven of the 10 babies are first born. All ten families are in poverty. Of these, seven are on AFDC. Five of the ten mothers are in the age range 16 to 18 years. Seven of ten mothers were not the baby's primary caregiver.

~~TABLE IV~~

INSERT TABLE IV Slide 5

Infants:

The babies, as a group, were among the most severely impaired children in our program judged by psychological criteria alone. Several of the children showed no signs of attachment to their mothers; they were solitary,

joyless, self-absorbed babies, some with odd mannerisms and dissynchrony in sensorimotor systems. Eight had affective and social impairments in the serious to severe range and five had cognitive/motor deficits in the same range. Mainly we can say that if these babies had not come to us with severe nutritional disorders we would have been alarmed at our findings of grave psychological impairment.

Yet, it is important to note that one baby in this group (Carleton, 30 months old) had a strong attachment to his mother and his mother was a devoted, loving and competent mother. His weight decline corresponded to a traumatic separation from his mother when a domestic crisis led to a temporary placement in his grandmother's home in another city. We saw his decline as associated with grief and mourning for the mother he had lost.

We are sobered by our finding that in seven of ten cases the mother was not, in fact, the baby's primary caregiver during an extended period pre-hospitalization for failure to thrive. The mother's employment, school, job training, or a family crisis had brought each of these seven babies into "substitute care arrangements of a kind that can only be described as "the desperate child care plans of the poor." These arrangements included the serial and evanescent baby sitters (neighbors, relatives, "anyone handy"), a grandmother in another city, a mentally disordered teenage father who was hiding out from the

police, and a day care center with multiple, shifting caregivers, mainly untrained. In these cases the baby was not only deprived of a mother, but deprived of a substitute mother.

Mothers:

INSERT TABLE I - Slide 4

6 21 → Now, if we turn to the mothers themselves, the picture enlarges in complexity. Our own diagnostic study confirmed the impressions of our referral sources in eight of the ten cases that there was grave impairment in the mother's ability to nurture her child in both the physical and the psychological sense of nurture.

~~TABLE V~~

However, two mothers could not be fairly described as depriving and neglectful. Carleton's mother we have already described as a capable and devoted mother. Angela's mother, otherwise devoted and caring, had produced a feeding problem in her baby through innocence and mechanical ineptitude.

For eight other mothers in this group we cannot speak of "neglect" or "indifference" or "rejection" in any of the ordinary uses of these terms. Six of these mothers exhibited signs of depression in the serious to severe range. While these mother's were manifestly "neglectful", if we mean not providing for the elementary needs of their babies, their own mental state was one of exhaustion, depletion of inner resources, and hopelessness. One of

3. THE DECISION PROCESS: THE TREATMENT OF CHOICE

At the close of the initial assessment period staff meetings are instituted to make treatment recommendations. The decision to take on a child for treatment at CDP is made entirely on the basis of need and whether we can best serve the needs of the baby and family.

We recommended treatment at the Child Development Project for nine of the ten babies in our FTT group. We recommended placement through the court for one baby, Lyle. Since we rarely choose placement as an alternative, and always prefer to try treatment even in the face of overwhelming odds, we should explain our reasons. Lyle entered the hospital at ten months of age, starving and in a state of filth and neglect. His mental and motor development were below the five month level. His mother showed signs of a severe thought disorder and his father was manifestly paranoid and dangerous. In interviews at our office the father threw furniture around and on one occasion nearly smashed a glass door. Both parents were members of an obscure religious cult. When we and the doctors at Mott Hospital told them of our grave concern for Lyle's life, the father said, "If he dies, he dies. God wants it."

Both Lyle and his sister were in extreme danger in this home. We know of no treatment which can help these two deteriorating psychotic parents in time to save their

children. The treatment of choice was placement.

Summary

We offered treatment at CDP to nine of the ten families. Only one family refused. The one refusal is of some interest. The teenage mother was employed; the teenage father was the primary caregiver. Mickey, the ten month old baby, was severely neglected and was in an alarming nutritional and psychological state. The young mother was concerned and caring, and Mickey was, in fact, responsive to his mother, but showed no recognition of or response to his father. The young father, when we met him, was incoherent, suspicious, possibly on drugs. In the course of our assessment we came upon a family secret. The father was hiding out from the police. Both parents refused treatment and took flight with their baby from the hospital and from us.

This was the only family which refused treatment at our clinic. Yet the family pathology which we identified in this case was not worse than that of several families in our FTT group.

All other families accepted treatment and sustained treatment for a period of six months to 2 1/2 years. This means that initially hostile and suspicious families, many with severe psychosocial pathology, often labeled "uncooperative", "unsuitable for psychological treatment", revealed an extraordinary capacity to work with us on behalf of their babies and themselves.

copy

among the physicians that anatomic anomalies were obstructing breathing and swallowing for Harry, and growth failure could not be attributed to maternal deprivation per se. We continued to provide services and treatment for Harry and his mother since they were manifestly in need of our help. But now, since Harry does not satisfy our criteria for inclusion in the study, we should not include him in our treatment outcome report.

INSERT TABLE VII - Slide 8
TABLE VII-

In the outcome summary that follows, we are now reporting on an N of 7. The attrition from an N of 11 to an N of 7 leaves us with too many facts for instant mental arithmetic. We'll now give a brief summary. Of the original 11 referrals, two babies were later found to have organic causes for growth failure. One baby was recommended for urgent placement. One family refused treatment.

Weight:

Seven of eight babies in the treatment group were fairly diagnosed as non-organic FTT.

All of these babies attained weight adequacy judged by percentile rank and medical opinion within the first five months of treatment. All babies in this group sustained weight adequacy during the extended period in which they and their families were followed by us.

Psychological:

As a psychiatric and pediatric team we should report that the work of bringing these babies to weight adequacy

was easier by far than the work that remained to undo the effects of early deprivation. The length of treatment (six months to two and one half years) actually represented the time that was required to work toward our second goal in treatment, which we call "psychological adequacy". By psychological adequacy we mean that the baby has attained stable love bonds with his parents and that he is utilizing fully his potential for learning and social adaptation.

The undoing of the effects of deprivation and the building of stable personalities in these psychologically damaged babies required the best skills of our psychiatric staff.

This work, we are glad to report, was largely successful. In a report which we expect to complete in another year, we should be able to give you the pre-post ratings on dimensions of psychological adequacy for the FTT children and other severely endangered children in our clinic population. In this preliminary report it is possible to examine our results with reference to published work in this area. Reports in the literature are sobering in their summaries of sequelae in FTT children. The residual psychological effects of deprivation are seen in the high incidence of feeding and sleep disorders, behavior disorders, social and motor retardation and abuse.

INSERT TABLE VIII - Slide 9
~~TABLE VIII~~

9 on → Among our treatment cases we can report no severe residual pathology in the affective-social sphere or adaptive capability. But in one case, the effects of early and severe deprivation on cognitive processes were irreversible. Mary Lou, "starving and grossly retarded when she came to us at 21 months, left us as a healthy, mainly affectionate child, greatly changed in personality. But her final testing on the Bayley showed the same degree of mental retardation that was measured in the first testing. One cannot know whether there would have been cognitive gains if Mary Lou had come to us earlier. But Mary Lou and her family, recent Appalachian migrants, had somehow escaped the good medical network which exists in our country.

9 f In the final part of this presentation we have prepared a video story which illustrates the progress of one FTT baby and her teenage mother through outpatient treatment in our program. This is the story of Nina:

*ERRORS IN DIAGNOSIS

*File - of failure to thrive
Frankley & Bennett*

Evans reports that on follow-up evaluation 5 of 45 (or 11%) "developed questionable organic difficulties which might have explained the original growth failure." In another study (not reported in this paper because of incompatibility in growth charts) Riley reports that 10 of 83 (or 12%) fall into an "Idiopathic Group." That is: "No satisfactory reason for growth retardation was discovered in these children, despite careful study during hospitalization." Other studies in the outcome literature on FTT do not report subsequent changes in physical diagnosis at follow-up or groups with undefined or questionable etiology. However, Evans' and Riley's data suggest that for a significant proportion of the FTT population intensive medical study may either be unrevealing (Riley) or subsequent medical study at follow-up may change the diagnostic picture in favor of organic etiology (Evans).

In the CDP population, periodic review of the diagnostic picture led not only to changes in physical diagnoses - 2 of 10 (or 20%) originally diagnosed as non-organic FTT were subsequently found to have organic difficulties which accounted for growth failure - but also to changes in the psychiatric diagnosis. 2 of 10 (or 20%) non-organic FTT referred to us with the diagnosis "maternal deprivation" were found not to be maternally deprived but to be suffering from other causes.

*CHANGES IN DIAGNOSTIC APPROACH

Three studies (Barbero and Shaheen, Hannaway, Glaser) raise questions about hospital diagnostic procedures for FTT. Because of his generally poor physical condition on admission and the scarcity of specific physical findings, the child is typically subjected to a multisystemic diagnostic approach which has iatrogenic effects. Strenuous laboratory and radiological examinations often result in further deterioration of the child's clinical status - i.e. further weight loss.

These authors, noting that change in the child's environment and the empiric use of some form of therapy often bring weight gains and clinical improvement, suggest changes in diagnosis for FTT. The traditional multisystemic approach should be abandoned: unless there are specific clinical symptoms or abnormalities noted on physical examination a period of observation prior to investigative or therapeutic procedures is an important, parsimonious and inexpensive diagnostic tool in its own right.

Slide 3 = Table VIII

October 24, 1978

Dr. Eveoleen Rexford
[REDACTED]
[REDACTED]

Dear Eveoleen:

I am looking forward tremendously to dinner with you and Suzanne.

I will tell you all of our news and would like to talk with you about the San Francisco offer. Yes, you have guessed right, I would be walking with Bob Wallerstein and would have a joint appointment in Psychiatry and Pediatrics.

Fondly,

Selma

Slide IV

TABLE III

Characteristics of CDP Sample at Intake

N=10	Characteristic
100%	Birth wt. approp. for gest. age & > 3%
60%	Male
40%	Female
70%	First born
100%	Poverty
70%	AFDC
50%	Mother's age: 16 — 18 yrs.
80%	Family headed by single woman
70%	Mother <u>not</u> primary caregiver

Slide V

TABLE IV
CDP INFANTS:
PSYCHOLOGICAL CHARACTERISTICS

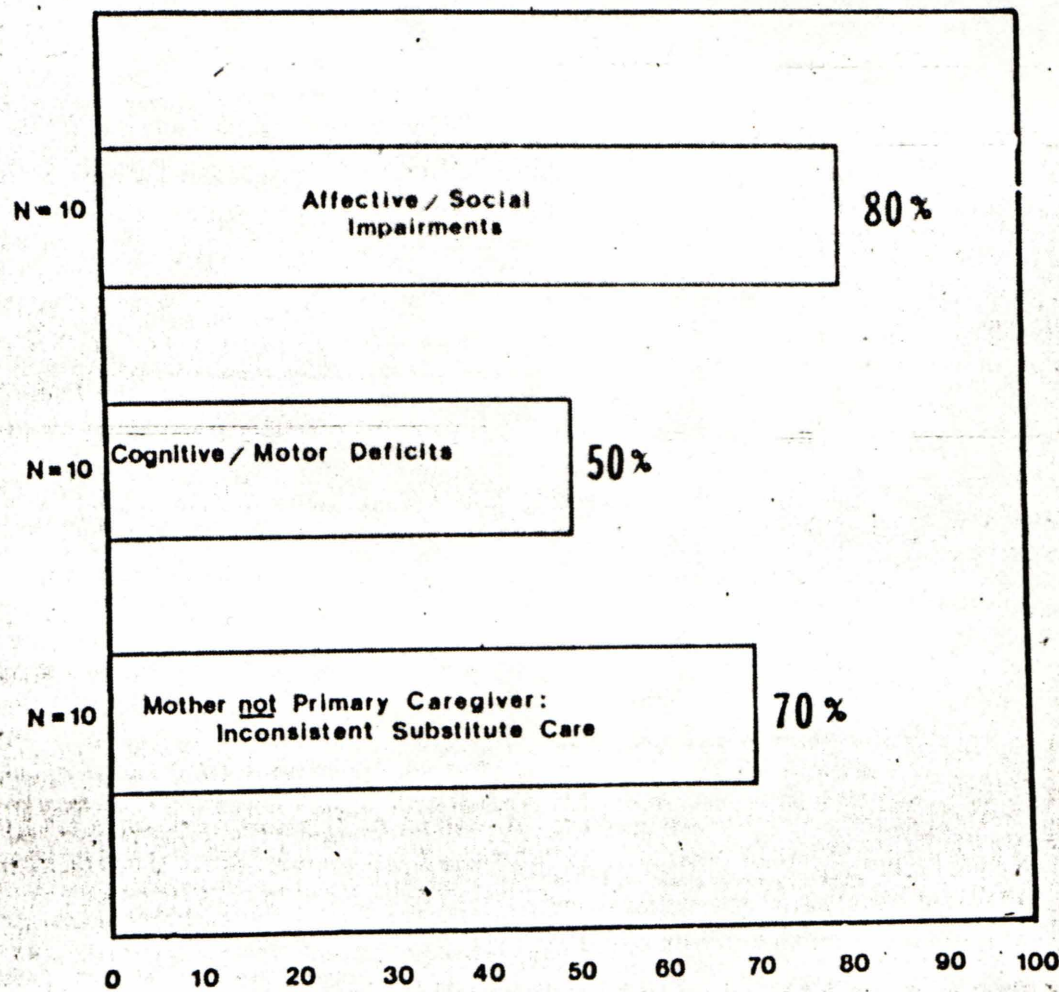


TABLE V *Slide 6*

Clinical Features of Maternal Deprivation - CDP

N=10

20% Mother not depriving.

60% Deprivation due to maternal depression.

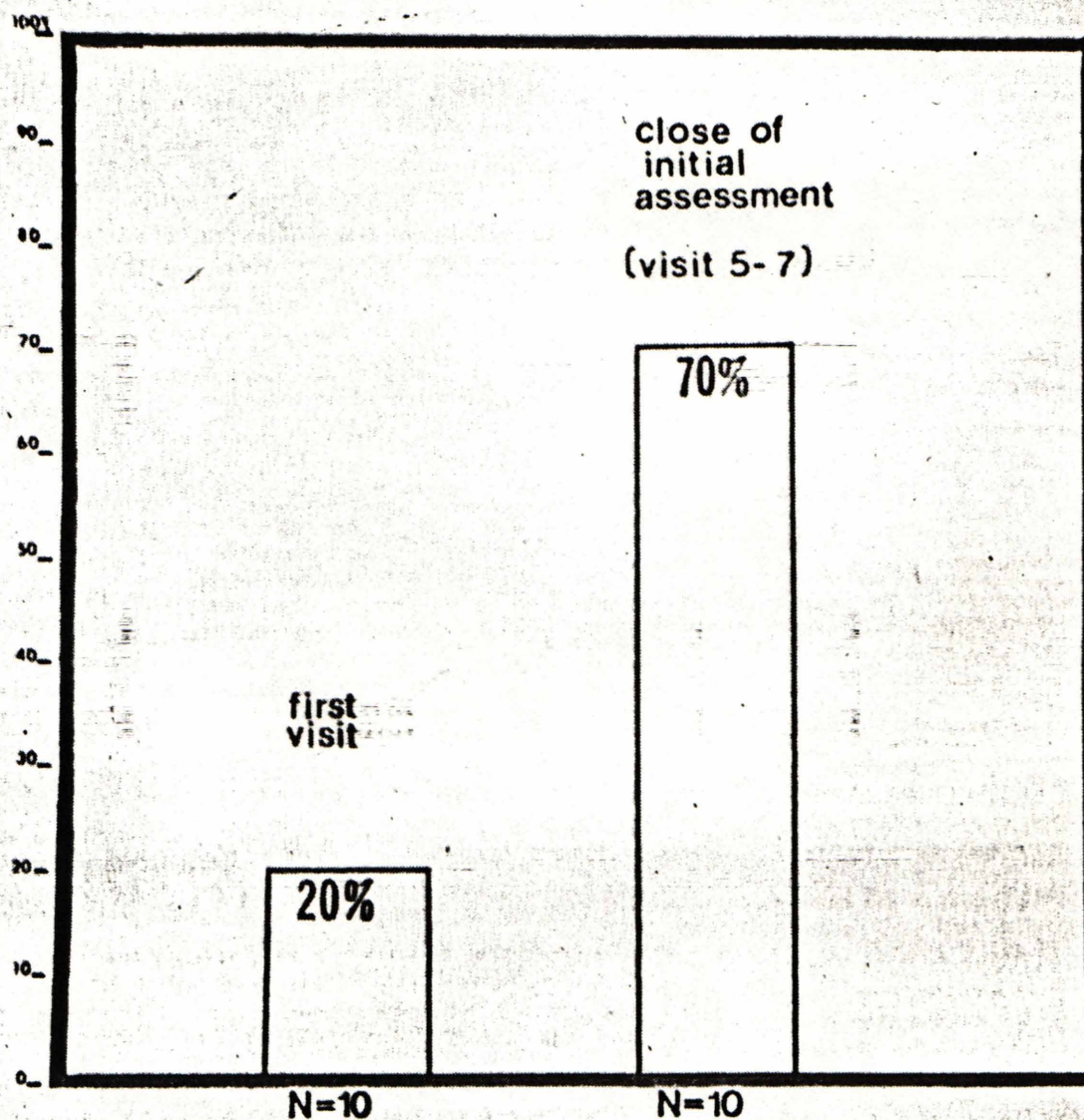
10% Deprivation due to maternal thought disorder.

10% Diagnostic picture unclear.

Slide VII

TABLE VI

Positive Attitudes Toward Treatment



Slide VII

TABLE VII

N at Intake / N at Close of Rx

N = 11 At Intake

- 2 Organic

- 1 Urgent Placement

- 1 Refused Rx

N = 7 CDP Non-organic Rx Group

Slide IX

TABLE VII

CDP OUTCOME

7 of 7 100% Wt Adequacy Attained Within 5 Mos.

7 of 7 100% Wt Adequacy Sustained During Rx Period

0 of 7 0% Severe Affective / Social Sequellae

1 of 7 14% Cognitive Deficits - untreatable

City and County of San Francisco



Department of
Public Health

San Francisco General Hospital
Medical Center

NOV 26 1980

November 25, 1980

Prof. Selma Fraiberg
Director, Infant-Parent Program
Ward 95
San Francisco General Hospital
1001 Potrero Ave.
San Francisco, CA 94110

File.

Dear Mrs. Fraiberg,

Thank you very much for your very stimulating discussion at Grand Rounds. You held everyone captive with your discussion even without the videotape.

We are all looking forward to hearing of the results of the Parent Infant Program.

Sincerely,

A handwritten signature in blue ink, appearing to read "Alan Goldsobel".

Alan B. Goldsobel, M.D.
Chief Resident
Dept. of Pediatrics

ABG/ag