PRESENTATION

NINA: DEVELOPMENTAL GUIDANCE AND SUPPORTIVE TREATMENT FOR A FAILURE TO THRIVE INFANT AND HER ADOLESCENT MOTHER

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PRESENTATION

In her paper, Mrs. Fraiberg, in the context of discussing developmental guidance, told you a few things about Nina and her mother, Karen. I would like to tell you some more about them. Not only do I want you to understand something about what happened to Nina and to Karen, but I would like to use them to try to illustrate what the things are that the therapist actually does in this mode of treatment. Also, I would like to re-emphasize what Mrs. Fraiberg said: that all actual work with any given patients involves multiple approaches and that when a case is called one of "developmental guidance" it refers only to its modal character and should certainly not suggest any exclusivity of method.

Nina was 7 months old when she was referred to us by her pediatrician. At that time, she was hospitalized for failure to thrive. Nina had not gained weight in four months, but during the hospital stay had eaten well and made normal weight gains. Hospital studies revealed no organic basis for the growth failure. The hospital staff and pediatrician were agreed that the primary cause was "maternal and emotional deprivation." Karen was 16 years old and unwed. She and her baby were supported by AFDC and were allowed, most grudgingly, to live in the home of the maternal grandparents. While Karen attended high school, Nina spent her days in a private nursery for young children. We were asked to provide an assessment of Nina and Karen in order to explore the possibility of providing continued treatment through our program. The initial assessment covered five weeks.

The first session was at the hospital. Nina was very much the center of this meeting, in discussion and in observation. The therapist consistently saw clear differential and preferential behaviors from Nina toward her mother; in gaze, smile and motor approaches. At the same time, there was one marked deficit. Nina rarely vocalized to her mother, and what vocalizations there were, were limited to the range of a 3-month-old -- just small grunts and squeals. Still, Nina sought comfort from her mother and demonstrated trust in and preference for her. The therapist expressed her pleasure in seeing these important expressions of attachment in Nina's behavior, and underscored them to Karen in terms of their meaning. The therapist told Karen what she had seen in watching them together and how that told us that to Nina, her mother was the most important person in the world.

Over the next weeks there continued to be many signs of positive and reciprocal attachment between Nina and her mother, but there were also things that were disturbing. I think it would be useful, at this point, to introduce you to Nina and Karen, as we saw them, shortly after we had first met.

(AT THIS POINT, THERE IS A TAPE SEGMENT OF NINA AT 7 MONTHS WITH AN ACCOMPANYING NARRATIVE)

While there were nine visits in five weeks, there were 17 appointments changed, cancelled or forgotten by Karen. Undismayed throughout, the therapist continued to respectfully, and with good grace, mend the contact each time it was broken. Karen learned that her therapist was someone who would not become angry and would not abandon her when Karen was conflicted and undependable.

We learned that, essentially, Karen was still very much of a child in her family's home--a home where there was chaos and violent, frightening quarrels between her parents. More history emerged. Karen, who had lost weight during a two-year period, weighed just 80 pounds when she conceived. Her long-standing amenorrhea masked conception, and only during her fifth month did Karen know she was pregnant. Karen resisted her parents' insistence that she give up her baby for adoption, and she and Nina became unwelcome members of the household--complained about, criticized, and belittled.

The nursery where Nina passed her days had little sense of the needs of babies and their parents, and provided unpredictable care for Nina and little understanding of Karen's need to be consulted and included in regard to her baby. Karen reported about all of this, but Karen neither cried nor reproached anyone. Instead, she would stare off, with a vague, fixed smile. When Karen's weight loss was explored, a description of a long-standing anorexia emerged. This anorexia was clearly associated with a depressive syndrome.

As a mother, Karen had affection for her baby, and there was no evidence of their being either anger or brutality toward the baby, or of gross neglect. But, she was clearly most uncertainly a mother. There was no claiming of her child in a firm, protective maternal sense. In addition to this, she had no idea how much a baby should eat at Nina's age or what an ideal weight might be. She did not know what to expect of a 7-month-old child. She was ready to begin toilet training Nina at 8 months. Should Nina be walking? Why didn't she understand the meaning of "no"? Why would it matter that a dozen people were taking care of Nina

at the nursery? Obviously, we could not limit our concerns to the initial one of nutritional adequacy for Nina. It was clear to us that an anorexic mother could not accurately read or respond to a baby's hunger signals without help. But it was equally clear that this same mother could not adequately respond to a baby in a far larger realm as well, without help.

Regarding defenses, we had been able to see during the assessment, that the therapist's attempt to elicit affect led to denial, blankness and withdrawal in Karen. Obviously, defenses were formidable and were protecting Karen form her unconcious anticipation that if her rage and grief were to be liberated she would be engulfed, or that she would destroy others--her parents, her child. Nonetheless, there was a good possibility that Karen would respond well to a warm, stable relationship with a therapist by whom she could be heard, understood and respected. She could also use a vast amount of developmental information, if it were provided skilfully, within the framework of the therapeutic relationship.

The first phase of treatment, roughly a seven month period, was focused on the mother-infant attachment, and on nutrition. With the full understanding on our part, and on Karen's part, that the two areas of concern were intimately related. In every session the therapist found ways to enhance the relationship between Karen and Nina and to demonstrate the centrality of a baby's attachment to her mother. Signs of preference were commented on: "Your mother certainly knows how to make you feel better." "It's your mommy you really want, isn't it, Nina?" Slowly, Karen began to recognize obvious behaviors in her baby as signs of love from her baby.

In the area of nutrition, Karen was given factual information which she could translate into planning meals. In addition, diet was discussed with their pediatrician, who recommended a daily record of Nina's food intake. Karen could not always follow through on all of the suggestions. What seemed important, however, was that someone else was making the decisions, and this removed the provision of food for Nina from the very center of Karen's own intrapsychic conflicts. This concrete planning, plus the good work and response in the area of human attachments, brought favorable changes in Nina's nutritional status within a matter of weeks.

Conferences with the director and staff of the nursery were an integral part of the therapeutic plan. A collaborative approach needed to be developed through meetings of Karen, the therapist, and nursery staff. Nina, as the only infant in a nursery which largely served a toddler group, seemed lost. There was no one there who stood in for Karen--no one to whom Nina had an attachment. Nina was usually fed by anyone handy. No written records were kept of her food intake or her general behavior during the nursery day. Older, aggressive children snatched toys from her or teased her while she looked on helplessly. In a nursery with eight to twelve scrappy and demanding toddlers, the forlorn complaints of one baby were often not heard.

Gradually, Karen's central importance for her baby was acknowledged. The nursery staff made special efforts to invite Karen to make frequent visits to the nursery, and to have Karen feed Nina her lunch. Nina was assigned a primary care-giver in the nursery. While not all of the plans made worked out ideally,

there came to be enough continuity, finally, in the relationship between Nina and one or two aides, to give stability to a situation that had had none, earlier.

Meanwhile, Karen welcomed the comfort and justified praise which came to her from the therapist, and began to experience pride in her child and in herself, as a mother. Karen, who in her family, "could never do anything right," began to blossom in the supportive, non-critical climate which valued her as a young woman, and as a mother. We need to remember that all along the line everything involving this young woman and her child had consistently been viewed negatively and as a problem. This will almost always be true of a situation in which an unwed teenager has a child. Often the infant-parent therapist is the only one who has ever found anything good about any of it. The therapist then puts to good use whatever pleasure and pride there can be, and this results in a very powerful alliance.

As Karen could be heard and understood, she moved toward becoming a mother who could understand her child. When there was grief and disappointment for Nina, Karen could now be touched by it, as she could not have been before. She could understand Nina's pain in separation at the nursery and she could find words of comfort and sympathy for Nina. These reassured Nina, and made the separation less painful.

By the time Nina was 14 months old, Karen could justifiably be described as an empathic mother.

(AT THIS POINT THE TAPE AT 14 MONTHS WILL BE SHOWN)

At this point, we entered a second phase of treatment. Although Nina had attained nutritional and psychological adequacy by the age of 14 months, our clinical assessment indicated that treatment should continue. We could predict that Karen's own unresolved conflicts would surface in the course of her child's development. If we were present throughout the period of early development, our relationship with Karen would advantage us greatly in helping her deal with developmental problems as they emerged. This turned out to be true in a number of areas.

When Nina was 15 months old, we began to get reports that she was cranky at bedtime and at bathtime. She was obstinate and was having temper outburst, protesting going to sleep and wakening at night. Careful exploration regarding all of these symptoms and their surrounds, eliminated many possibilities and suggested that we should make very tactful inquiries around toilet training. Karen, ready to toilet train Nina at 7 months, but dissuaded, was ready again at 15 months. When the therapist finally suggested that Nina's behavior might be related to some unreadiness, and sketched for Karen Nina's dilemma of wishing to please her mother but being unable to do so, Karen bristled. Karen, usually too compliant, tightened up visibly and either spoke with muted anger or remained tensely silent. She could make no use at all of the therapist's ideas or suggestions and pursued toilet training with determination. Her reactions to discussions about difficult incidents that arose with Nina, ranged from avoidance to sullen denial of their being any problems at all.

As we reviewed the sessions, it became clear that Karen was reacting as if someone were forcing her to be toilet trained. Whatever profound conflicts training her child touched in Karen, they were not readily available to us, but we did need to free her from them, so that she might use our help with Nina. Karen's current conflict, on the ego side, between "autonomy and submission," (in Erikson's terms) might be reachable. In essence, what gradually happened, was that as the therapist accommodated to, and spoke to Karen's negative feelings about being "given advice"--and the naturalness of her resenting this--as she supported Karen's assertion that "she was the one who knew what was best for her child," Karen's expectations for Nina moderated. As the therapist suggested to Karen that in effect, they needed to cooperate around finding ways to help Nina with this, Karen began cooperating with Nina, expecting her to exert control when she was with her, for example, but not during their separations. She began to understand Nina's wish to please and to try, and to respect the natural fluctuations in her ability to do so. Soon, the training was proceeding smoothly, and the symptoms were at an end.

Karen began, shortly after this, to focus much more on her long-standing concerns regarding her family. It was at this time, too, that her first therapist moved away and the work needed to continue with a new therapist.

Much time was spent with Karen and Nina, in helping them to experience and to deal with their loss. Gradually, a relationship of trust, abetted by a legacy of trust from the first therapist, was well established between Karen, Nina and their new therapist.

There was, at this time, a rather contrasting picture between mother and child. Nina was eager, lively, delightful, and engaging. Karen was reserved, quiet, passive, somewhat withdrawn, and clearly still depressed. Despite this, many things were going better. Nina was in fine fettle. Here are Nina and Karen when Nina is 28 months of age.

(HERE WILL BE THE INSERTION OF THE 28 MONTH TAPE OF NINA AND KAREN)

As Karen continued to describe her family in great detail, she shifted from being more self-possessed and articulate within the sessions, to being more and more withdrawn and lethargic. She consistently reported lack of appetite, weight loss, insomnia, headaches, and dizziness. Frequently, it seemed that in the sessions themselves, Nina or the therapist was having to recall Karen from some sad, distant reverie. At other times, it seemed that only Nina had the power to elicit a smile from her mother.

As Karen thought of the future and finishing high school, she felt overwhelmed at the prospect of trying to sort through what she should do and how she could possibly work, continue school, and somehow take care of Nina.

Despite descriptions of her parents' treatment of her, their insensitivity and the minimization of her needs and feelings, Karen rarely experienced any anger toward them. Instead, she resolved her ambivalence with a shrug of helplessness and some somatic expression.

Until this time, of course, all treatment sessions had included both Karen and Nina. Given Nina's age and comprehension and her mother's troubling symptoms with her attendant withdrawal, it seemed that both Karen and Nina might benefit from Karen's having

individual sessions. It was hoped that this would provide an opportunity for discussion not always possible with an active preschooler present, and would also demonstrate respect and concern more directly for Karen's own needs and feelings.

Thus, as occasionally occurs in our work, the situation called for a modification of the usual parent-child sessions. The regular joint sessions changed from weekly to every other week, and additional weekly individual sessions were offered to Karen. This plan continued until treatment ended, when Nina was 38 months of age.

During this last ten months of treatment, although Nina was seen less often, she was still very much in the center of the work. Important connections between Nina's behavior and external events continued to be made by Karen and the therapist. When there were any difficulties, discussion of incidents quickly led to Karen's understanding and effective handling.

Nina had a period of toileting accidents, and was cranky and clinging. At one time, Karen would have been annoyed and frustrated and would have lacked any understanding of how to handle this. She would have had difficulty even discussing this with the therapist. Now, in conjunction with the therapist, she could link recent separations in the family to these "accidents" Nina was having. She could see how these separations could make Nina fear losing her mother, and Karen could reassure Nina that this would not happen. In time, this way of thinking about Nina's behavior became very natural to Karen. Instead of presenting problems, she began presenting solutions. With shy pride, Karen would describe not only the source of concern, but the way in which

she had dealt with it. Karen became increasingly able to control and change external events to Nina's benefit. Karen was able to mobilize herself, and to be assertive and active on Nina's behalf. When she felt Nina was not treated properly, she was able to express anger on her behalf.

This ability to express and to experience anger, and to act on Nina's behalf, remained in contrast to her ability to experience anger and to act on her own behalf. Any attempts, however gentle, to move Karen to some slight recognition of her own upset or negative feelings, continued to result in an increase in somatic complaints. Karen was able to say to her therapist that "I have been holding back feelings for so long that I simply do not know what they are anymore." Affects momentarily there were quickly lost, and Karen would become mute and remote. Karen would become extremely uncomfortable if the therapist merely wondered with her whether there were times when she might disagree with the therapist and feel uncomfortable saying so. Over a period of weeks, it became clear that Karen could not use even the most delicate and tactful of such suggestions, imbedded though they were in the structure of general support and guidance.

Nonetheless, there were ways of structuring visits that proved very useful to Karen. Focusing on Nina, and understanding the way events effected her behavior, was the one way in which Karen could experience the relationship between her early experience and feelings, and her present feelings and difficulties. Karen was not yet ready for sustained exploration, but she could benefit

from the meaningful glimpses and could say so. Seeing Nina in certain situations evoked memories for Karen which she could link to early feelings of her own. As Karen watched her own mother begin to make many demands on Nina, Karen was able to remember the resentment and sadness she had experienced as a child. Karen was able to talk about Nina's assertiveness in contrast to her own passivity. She recognized her encouragement of Nina's assertiveness and began to think about why it was that she wanted Nina to be so assertive, and what being passive meant to her.

Throughout this difficult time, Karen never missed an appointment, and it was evident that she continued to perceive the therapist as both committed to, and concerned about, both Karen and Nina.

With the end of high school soon approaching, Karen had to decide whether and how she might to go college. Only during these sessions, spent considering alternative schools and jobs, did it become clear to the therapist, and probably to Karen, that Karen was a very capable student and that she had long cherished a dream of college. It also became very clear that Karen was setting up all kinds of obstacles toward achieving her dream. Dreams were fine, but in fact she was not applying for financial aid. The therapist engaged Karen in a discussion of what going to college meant to Karen, and then discussed how Karen's parents felt about her going to college. Karen said, "My parents think it's a big joke." Karen said they had never asked her about her schoolwork, and that they always belittled any of the courses in

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which she did well.

The therapist said it sounded as if Karen's family had very different ideas about why one went to school and what courses were important. The therapist acknowledged that Karen had given a great deal of thought to school, that she had abilities and plans which she very much wanted to pursue. This very straightforward response and discussion of the situation, enabled Karen to reconfirm her interest. Suddenly, the financial difficulties no longer seemed insurmountable, and Karen could apply for financial aid.

Her decision to go to college also led to Karen's separation from her family. She had her choice of two schools--one close to her family and the other in a nearby community. By choosing the farther school, she created a rationale for moving out of her parents' home which did not necessitate her confronting either them or herself with any negative reasons for the move. The therapist discussed with Karen what she wanted and how she might proceed. This involved a careful examination of how Karen would present her plan to her parents, how they were likely to respond, and how Karen would handle their responses. Also, the therapist commented that leaving home involves, for many young people, a sense of ending a very important period in their lives. She said that this feeling might be even more heightened for Karen, because at the same time, Nina was moving on to greater independence. This transition allowed the focus to shift to Nina, a focus with which Karen was more comfortable. In that framework, as they talked of what Karen wanted for Nina, despite the loss she might feel, Karen was able to realize that the move from her parents'

home meant to her that she would never have the attention, valuing, and love from her parents for which she had longed. The kind of parent she wished to be to Nina was a way her parents had never been able to be with her, and never would be with her. When these feelings were experienced and talked about, some of the ambivalence which had been keeping Karen from actively planning for the new living arrangements, was sufficiently resolved for the move to take place.

Nina was directly and profoundly affected by moving. The relocation to a nearby community meant leaving both her grandparents' home, where she had lived since birth, and also the nursery where she had spent the last 18 months. She was the youngest among the children at her preschool center. In her typically active, coping style, Nina emulated the older children and quickly established herself with them in quite a sturdy fashion. Her reactions to all the changes that had occurred, however, were touchingly apparent in the play sessions.

Nina began trying to climb into the dolls' bed and into the dolls' highchair. At the same time, she also began climbing on the furniture in a dangerous way. When the therapist reflected that this seemed to give a very graphic picture of the feelings that Nina must have about being the baby and being the big girl, Karen immediately felt this was true. She connected it to the recent moves and spontaneously provided Nina with a lot of opportunities to be cuddled and babied and played with by her. Karen managed beautifully to avoid infantilizing Nina in some detrimental way, yet provided the freedom for Nina to express her wishes and feelings. After a few weeks of an unusual amount of

cuddling, Nina seemed comfortable and began again to enjoy the more typical imaginative doll play which had filled her time before. Much of this doll play expressed Nina's pleasure in being a good and loving mother, like her own.

There are other ways in which the focus on Nina allowed direct freedom for Karen to experience some of her own feelings. Nina's energetic play was usually very charming, but on occasion she was quite capable of very demanding and irritating behavior. The therapist increasingly felt that Karen was really exceptionally patient and tolerant of Nina's unpleasant behavior--to a fault. When the therapist merely commented, finally, on Karen's surprising patience, Karen explained that if she acted or felt angry at Nina she felt very bad and guilty. One of the things the therapist and Karen learned, as this was discussed, was that in addition to Karen's own internal difficulties with anger, the therapist had unwittingly contributed to the situation. All of the tolerance for Karen, and the understanding and patience toward both parent and child, had been "taken over" by Karen as a model. It was as if she really thought she had not been "given permission" to be annoyed at her mischievous, assertive little girl. This became an important topic to be discussed and understood, and although truly basic shifts simply could not happen, our role in this could certainly be dramatically modified.

When Karen began to understand that a mother could love her child very much and still be angry with the child, there began to be perceptible changes in Karen. She became discernibly more relaxed and active and allowed more irritation and anger to show both toward Nina directly and in speaking of her parents. Some of

the entrenched defenses against anger shifted as, through gentle support and acknowledgement of her feelings, Karen could experience that having both positive and negative feelings toward Nina was expectable, allowable, and most important, not dangerous. The reassurance seemed to occur as she gradually experimented with experiencing and acknowledging more negative feelings, and found they could be acted upon comfortably and appropriately. She learned she did not need to fear either herself or Nina.

Karen became more consistently active and involved, and she began to look more rested and relaxed. She began describing how she was trying to help Nina to express anger, letting Nina know that it was all right to be mad, to talk about it, and then to make up. Simultaneously, she began telling the therapist, with appropriate affect, of her annoyance with her parents, at their behavior around her college plans.

With this acknowledgement, at last, of anger toward her parents, significant changes took place. Karen now began to separate from her parents emotionally and in reality.

As these changes were becoming stable, the therapist began discussing with Karen how she thought they might usefully use their sessions. Karen still had many of the same difficulties: she continued to suffer some somatic complaints, she was still sometimes passive, sometimes sad, and failed often to experience the painful affect that her manner and behavior still reflected. She did not, however, experience these things as problems--or at least as significantly interfering. She had made very important changes in her life, increasing her opportunities for

satisfying relationships and a sense of self worth, and she was a consistently sensitive and responsive mother to Nina.

Of great important and significance was the fact that she had maintained a very positive and rewarding relationship with a young man, for some time. He was someone who valued her, treated her well and made her feel important and cherished. It seemed to us reassuring and promising that she could enjoy this, and that she did nothing to either spoil it or destroy it.

Nina was thriving in every way. Thus, when Karen did not feel that there were concerns and problems on which she wished to focus, but instead could express some hesitant pleasure in the possibility of independence, the therapist introduced the idea of an ending point for their work.

Long before the changes in Karen's and Nina's situations had been made, the therapist had suggested to Karen that Karen was not always going to need someone to help her, and that the therapist was confident that Karen would sometime be able to do very well on her own. It was made clear to Karen that ending was a possibility to be considered together, when the situation was stable. When this occurred, Karen was ready, if not eager, to terminate. The time at which they would end was mutually agreed to. Karen and the therapist reviewed the work they had done and reaffirmed Karen's continued competence as a mother. The therapist spoke of the work as a confirmation of Karen's own very good ideas and knowledge, pointing out that while Karen, at times, had needed some help in determining what was best for Nina, she had mostly needed support in order to do what she felt was best.

To this, Karen responded that long ago, in their initial meetings, the therapist had been the first to make Karen feel that she had the right and the capacity to be Nina's mother. Karen said that even in the first months of treatment, "I never felt I was a bad mother when I came here. It was really nice to come and know that I was doing something right. It was very reassuring. People here knew I couldn't do everything right, but that I certainly tried." The therapist said that she knew that it had been hard for Karen, because Karen had not had support at home, and every mother needed that. Karen then said that during the past year she guessed she should have known that things were all right with Nina, just by looking at her, but this was still very hard being with her family, and again, she needed to know she wasn't doing things wrong. Karen now felt confident about herself, and while shyly sad about termination, was able to say that "ending is taking a step forward for myself."

Eight months after termination, Karen called the therapist and wanted additional information about financial resources they had discussed. At that time, the school situations were still stable, and Karen reported that she and Nina were living with a good friend, one of several who supported their interests and endeavors. From her descriptions, it sounded as though Karen had found a new "family" in which both she and Nina were valued and nurtured. This was confirmed, some months later, when a whoop of joy was heard from the office of Karen's therapist. Investigation revealed that this loud but happy noise was a spontaneous response to the therapist's having received a wedding invitation from Karen.

This was surely an outcome to please the most demanding, and an unexpected and happy extra reward to all of those who worked very hard and very well.

TAPE NARRATIVE

Here are Nina and Karen shortly after they were first referred. They are visiting our playroom. They have been here four times before. On this day, Nina is 7 months and 26 days old. Karen is just 17.

Nina, as you may remember, had failed to gain weight for three months preceding the referral. There was also a decline in the height curve.

The person who is going to administer a Bayley Developmental test to Nina is giving both Nina and Karen a chance to adjust to this new situation. Following the testing, there will be a period of free play and observation for both the mother and the baby.

Nina will do well on the Bayley. She will pass all items through 7.8--her age level--all but one. On the mental scale her raw score will be 86; in the developmental index 110. But, of course, the numbers do not tell us the story. The one item Nina fails is a significant one. She is unable to verbalize different syllables. She cannot do this either during the testing, or during any other periods of observation. There are no vocalizations from Nina beyond a grunt

and a weak protest. And, in case you are wondering, this is true even when the pacifier is out of her mouth. We too, were struck from the beginning of knowing Karen and Nina, by the constant availability of a pacifier. Whatever the circumstances, when Nina pulls it out, Karen puts it back. This happens very, very often. We have wondered if such a constant source of imposed tension reduction colors Nina's responses--mutes them. We also wondered, of course, why Karen needs, so uncontingently and constantly, to orally pacify her daughter.

Nina's face is mirrored in her mother's face. Karen is sad and distant and her face expresses her depression. We watch Nina, and although she is passing the items, we are concerned as we watch her motor performance. She approaches toys with an awkward flat hand--fingers rigidly extended. We see poor integration of sensory-motor schemas.

Nina grasps a toy but does not look at it.

Or Nina looks at the toy but does not grasp it.

Nina sounds the toy, but does not look at it.

She startles easily to sound, too.

When frustrated in a task, Nina does not persist. She does feel she can act upon circumstance--why try.

She finds the toy, but there is no pleasure in her accomplishment.

Very often we see Nina staring into space. At no time do we see her joyful, or enthusiastically engaged.

We are struck by the fact that Nina rarely turns to her mother--to restore contact--to seek comfort, or to share with her mother a moment of pleasure. Karen rarely speaks to Nina, or maintains contact with her during the testing.

But there is one moment when we do see reciprocity between Karen and her baby. It is really the only such moment that we have on tape. It is a moment that we will remember, and one of the things that reassures us that indeed, we can help this young mother and her baby.

Karen decides to feed Nina. At the hospital, at the very first meeting, there was a point when Nina uttered a complaint and turned to her mother. Karen decided Nina was hungry and she arranged for a bottle to be brought to her. Karen then held Nina in her arms and Nina settled comfortably, much like we see here. After a few sucks, she offered the bottle.

Karen seemed at a loss, and could not interpret the refusal. When the therapist asked when Nina had last had a feeding, Karen said, without making any connection for herself, that Nina had had breakfast one hour ago. Karen, anorexic, cannot properly register the signs of hunger in herself. Neither can she properly register the signs of hunger in her baby.

CUT OUT 9 MONTH SEGMENT

14 MONTHS SEGMENT

Here are Karen and Nina in our playroom. Nina is now nutritionally and psychologically adequate, and Karen is a justifiably proud and competent mother. Karen has gained some weight. But although she looks better, she is still very depressed.

Nina has gained weight steadily. She is now just below the 25th percentile.

The developmental testing shows marked gains. At 14 months Nina's MDI on the Bayley is 133. At 7 months, her MDI had been 110. Whatever else, the difference between the two scores reflects a tremendous difference in language. The silent child has become positively garrulous.

This is part of the developmental testing. Nina is involved and persistent in undertaking a task. She is also very, very proud of herself when she solves a very tough problem. The marked restraint of the adults undoubtedly adds to the situation.

She protests when the tester, utilizing those sneaky ploys of testers, rudely substitutes one item for another.

We pay close attention to her hand in these pictures. Coordination is excellent. The motor stereotopy, which we saw a 7 months, has disappeared. The very

The very slight arching of the wrist that remains will disappear in the few weeks. It was a very good integration if sensory-motor schemas in her exploitation of toys. Her face is bright, animated and vacant staring is gone.

Now there are many moments of intimacy between Karen and Nina. Karen believes that she is the most important person in the world to Nina. Karen is very tender and soliticious to her baby, and Nina, like all babies who are treated lovingly, reciprocates with very, very large rewards.

Though Karen looks quite radiant in some of our pictures, she is still depressed and still anorexic. But she is able to rise above it, despite the depression. She is able to summon resources to meet the needs of her child. In very many ways she cannot feed herself--but she can feed Nina.

File

28 MONTH SEGMENT

We are watching Nina busily engaged in the playroom. Also present are the mother and her therapist.

Nina is doing very well in all areas. Nina's weight curve and height curve are extended here to 28 months. She has nicely sustained all gains and is functioning at a superior level in cognitive development. More important to us is her animation and joy and her very strong affection for her mother.

Nina spends this hour in play with the dolls and includes her mother and her therapist in the play.

Lunchy-lunchy-lunch is ready. Nina is preparing lunch for everybody. When a former failure-to-thrive child makes lunch for everybody, it does feel like a very special occasion.

Here is the spoon--here's yours, here's yours. As clinicians, we hope that the food will be prepared with pleasure and served in tempting ways.

We are very pleased to see her sustain the play so nicely, with no disruptions. It strongly suggests that food is not an area of any serious conflict for her.

Eat it, Mommy, eat it, eat it. And Karen laughs. We see the evidence of Karen's difficulties in this sequence, but we do not see any evidence of conflict in Nina--no residues in her of the difficulties that brought them to us when Nina was 7 months old.

Nina feeds and plays with her own babies with care, warmth and interest. A clear reflection of the mothering she has received from her own mother.

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