

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

BERKELEY • DAVIS • IRVINE • LOS ANGELES • RIVERSIDE • SAN DIEGO • SAN FRANCISCO



SANTA BARBARA • SANTA CRUZ

SCHOOL OF MEDICINE

Please address reply to the undersigned at
UNIVERSITY OF CALIFORNIA SERVICE
SAN FRANCISCO GENERAL HOSPITAL
SAN FRANCISCO, CALIFORNIA 94110

July 31, 1981

Dr. Sherman Feinstein
[REDACTED]

Dear Dr. Feinstein:

Greetings again! I think back many times to our meeting in New Orleans.

I'm enclosing a modified version of the paper I presented at the New Orleans conference which you suggested I send on to you for possible inclusion in the Annals to the American Society for Adolescent Psychiatry.

Do let me know if this reads clearly and if you have any comments that you'd like me to incorporate in the text.

With best regards,

Cordially,

Selma Fraiberg
Professor of Child Psychoanalysis
Director, Infant-Parent Program

THE ADOLESCENT MOTHER AND HER INFANT

Selma Fraiberg

In this paper I will describe our work with adolescent mothers and their infants in an infant psychiatry program. In the first part of this paper I have gathered together some of our clinical observations of a group of young mothers struggling with formidable developmental conflicts of adolescence and their new and uncertain identity as mother to an infant. In the second part of the presentation, I will describe our treatment of one 16-year-old, severely depressed mother and her failure to thrive infant.

As the basis for this presentation I have chosen a group of ten babies and their eight adolescent mothers who constituted a subgroup in our intensive treatment caseload in our University of Michigan program during the period November, 1972 to October, 1978. The ten babies represented 20% of our intensive treatment caseload of fifty. Since the only criteria for entering our intensive treatment program were our assessment of need for this form of treatment and the practical limitations of a small staff, it is important to note that teenage mothers constituted a substantial number of those we had identified as severely impaired

in critical areas of functioning.

Characteristics of the Group:

The ages of the mothers at the time of delivery ranged from sixteen to eighteen. Five were unmarried girls. Of the three mothers who were married, one was separated from her husband. The five fathers in the never-married group are unknown to us, and in fact, broke connections with the girl soon after pregnancy was confirmed. They appear in our records as nameless and faceless, and in each case were partners in casual encounters.

Seven of the ten babies were firstborn. All of the babies were full term with birth weights within the normal range. Congenital defects were later identified in three of the children. All of the mothers were living in poverty. The five unmarried mothers were supported by AFDC. In nearly all cases the young mother was living apart from her family of origin, and encounters with the extended family were caught up in conflict and turmoil. There were neither psychological support for mother and baby nor traditions of childrearing to guide a young girl who was unready for motherhood.

The five unmarried mothers were attending school or were enrolled in job training. Their babies were being cared for in day-care centers or family day-care. Mainly, the day-care arrangements, which we ourselves could assess through visiting, were poor, and offered little more than custodial care. In three

cases there was outright neglect of infants. As we came to know the babies and their families, we were sobered by the fact that the child, endangered by the considerable pathology in the mother, and already showing signs of a severe attachment disorder, was further endangered by the circumstances in which he received indifferent or neglectful substitute mother care. The baby who needed an optimal day-care program was receiving substitute care of the poorest quality.

The babies and their mothers had been referred to us by physicians, nurses and social workers in Washtenaw County (population approximately 300,000). The babies of teenage mothers were, as a group, among the most severely impaired children in our caseload. A primary attachment disorder was present at the time of referral in each case. Four of the babies had been hospitalized for failure to thrive. The teenage mothers, as a group, showed grave impairment in psychological functioning and were virtually incapacitated in mothering a baby. Although they had been labeled by their community as "neglectful" and "rejecting", none of them had been evaluated by a psychiatric team until they came into our program. Ideally, we would like to see a psychosocial assessment of the teenage mother in every case, at the point where the pregnant girl is first identified by the health provider. After our own diagnostic study, six of the eight mothers were seen by us as severely depressed. Depression in each of these cases

had been present for many months and even years before the baby was conceived. In fact, as I shall later discuss, depression and the unsatisfied psychological hungers which were entwined with depression, had found their way into longing for a baby.

Developmental Conflicts of Adolescence and Motherhood

When I speak, now, of the interlocking development conflicts of adolescence and motherhood which we saw in this group of young girls, I should preface these remarks with some caution. Clearly, the group of severely disordered teenage mothers in our caseload do not represent the larger population of teenage mothers, in which we can find a fair amount of adequate or excellent mothering. And when I describe the adolescent conflicts and mothering conflicts which we encountered, they are not typical, I feel, but are exaggerated and heightened conflicts, in which universal problems of adolescent maturation become distorted by disorder in the adolescent personality and the inability of the primary family of the girl to provide the vital pathways to resolution of conflict. The girl and her family, in our cases, were locked together in a morbid conflict.

The diagnostic study and treatment of this group of young mothers and their infants brought into focus the interlocking conflicts of adolescent development and mother-infant relationships. Each of these mothers had become pregnant at a point in psychological development when attachment and detachment from the primary family figures had produced conflicts of considerable magnitude.

The unresolved conflicts of adolescence became the focus of new conflicts which embraced the child. The attachment and detachment problems of the mother were mirrored in the disorders of attachment which we saw in the baby.

The baby was caught up in the morbid past and uncertain present of his mother, but he was also most poignantly the symbol of hope and self-renewal in his mother. Each of the unmarried girls, it should be noted, had examined the alternatives of abortion and adoption, and had chosen to keep the baby. They wanted their babies and kept them against the wishes of their own parents. In each case, the baby, when we met him, was manifestly neglected and showed impoverishment in all areas of human attachment. The contradiction between the adolescent mother's daydreams for the baby and the actual state of the baby needed to be understood.

As we came to know these adolescent mothers, we saw how many of the typical conflicts of adolescence had become intensified and magnified for each of these girls before they became pregnant. Their own mothers were at the center of these conflicts, and by the time we came to know them, these conflicts appeared to consume the life energies of each. In normal adolescence we may see the love-hate conflicts of the girl surface in daily life, but after the storm the beloved aspects of the mother can be reclaimed. What is preserved and eventually consolidated in the course of adolescence becomes available for positive identification and

integration of personality in late adolescence. But among the young girls in our group, the mother as enemy and betrayer dominated the theater of conflict, and there appeared to be no aspect of this mother that could serve maturation and identification. It also seemed to us that the mothers of these girls had become the unwitting collaborators in this tense family drama, transforming themselves into the enemy, so that the fantasy mother and the real mother sometimes merged.

Side by side with these consuming struggles with the mother was dependency in the girl and a longing for nurturance from the mother, which was explicitly brought to us in their stories and re-enacted in transference with the therapist. Often, when the therapist was visiting the young mother and her baby in the home, there were two crying children in that living room.

The unresolved mother conflicts of the girl became impediments to mothering and to the attachment of the girl to her baby. A girl who is fighting against her tie to her mother, who sees her mother as an enemy without redeeming features, has nothing good or solid to hold onto when she seeks a model for herself as a mother. And a girl who is still longing for a mother, who wants a mother to hold her close, nourish her, is not ready to become a mother herself.

Much of the important work that we accomplished in our treatment of these teenage mothers grew out of our exploration of the

mother conflicts which were paralyzing the girl in her own psychological development. We examined the love-hate relationship to the mother, as they were described to us and as they were re-enacted in transference to the therapist. We provided, through our treatment, a form of psychological nurturance for hungry girls. We offered a relationship in which independence could grow out of dependency, and affection and trust for the therapist could provide the conditions for new identifications with an adult figure and alternative models for mothering. The listening and understanding which the therapist gave the young mother could be transformed into listening to and understanding of a baby. Again and again, in our records, the therapist is in a room with a crying mother and a neglected and crying baby, and the therapist offers words of comfort to the mother and the mother turns to the crying baby as if she has heard him for the first time.

The adolescent girl's father, as he was described to us and revealed through the eyes of the girl, was also at the center of love-hate conflicts. We expect that in the normal adolescent process the girl's attachment to her father is gradually modified, that the oedipal wishes and fantasies are transformed and that resolution paves the way to the discovery of new partners in love. Among the adolescent mothers in our group, the childhood daydream of father-love had been preserved and was re-enacted with male partners who appeared as transient lovers - if, indeed, the word

"lovers" should be used.

Since the attachment to the father was still primary, there was no possibility of forming an enduring bond with another male partner. Typically among our girls, sexual activity had begun at the age of 13 or 14. The sexual partners were distantly remembered and seemed to have no more substantiality than figures in a fantasy. And, in fact, the sexual experiences resembled fantasies in which each partner was interchangeable with the other, like the masturbation fantasies of early adolescence. What was acted out in these transient sexual episodes was the fantasy of forbidden and dangerous love, a transparent oedipal fantasy. When pregnancy occurred, the unconscious childhood fantasy of having a baby with the father added another psychological dimension to a crisis, and the baby, when he arrived, became the embodiment of a shameful secret, a "child of sin", in the old-fashioned phrase.

The baby was also the child of a profound disappointment, the result of a promise that was not kept by whoever it is in our society who makes promises to the young. In the hyped-up sexual climate of our times, it is easy for the young to believe that puberty carries a passport into sexual bliss. But not one of the young girls in our group had experienced sexual pleasure of any kind in their many encounters. In fact, the serial encounters were motivated by the search for sexual joy. "It'll be different with the next fellow." But it never was. These girls were, in

fact, unready for sexual fulfillment, like the majority of adolescents in their early and mid-teens. But clearly, for the girl we are speaking of, a girl who is still pursuing a childhood fantasy love with her father, there is no place yet for a new partner and uninhibited sexual joy. The father-love becomes the inhibitor.

The father-love also becomes an impediment to motherhood. A girl who is still playing out an unconscious childhood fantasy of make-believe love and make-believe union with her father is likely to continue this fantasy as a make-believe mother with a make-believe baby. And this, in fact, is what we saw when we first met the mothers and babies in our group. Motherhood was somehow unreal. The baby was not quite real.

In our infant-focused psychotherapy we listened to the tangled stories of fathers and lovers, and helped the adolescent mother to find new solutions to old griefs and old longings. As we watched the mother and her baby together in session after session, we were attentive to those aspects of the baby and of mothering which were caught up in the old daydream. Where the baby was somehow unreal, and motherhood was unreal, we could make them real. This was not a fantasy baby to us; he was a person with all the unique qualities of his own personality. She was not a pretend mother, to us; she was a real mother with real concerns for her baby and real problems. We played with this real baby and revealed his marvelous attributes to his mother. We

talked to the real mother and most respectfully gave her the authority and prestige of mother. She was not a child to us, innocent and blundering, but a mother trying very hard to be a mother in the midst of terrible hardship.

The unresolved conflicts of childhood embraced every aspect of the childhood family. Repeatedly, in our work with adolescent mothers, we saw intense sibling conflicts re-enacted with the baby. Jealousy toward the baby, competition with the baby, anger toward the baby, the feeling of being robbed of something precious by the baby, were recurring themes which we could trace back in treatment to a sibling who had been a rival in childhood. Normally, in adolescence, the sibling conflicts of childhood undergo resolution along with other early and intense love-hate relationships of the family. When the adolescent process has not been completed through maturation, the old jealousies and hostilities stand ready for transference to other objects. Tragically, in the case of teenage motherhood, the new baby may come to represent the old rivals in the family of childhood.

In our work with the adolescent mother, we examined those ways in which the baby was caught up in old memories and the conflicts of the childhood family of the mother. We helped the mother to disentangle her baby from the figures of childhood and free the baby from the ghosts in the maternal past.

The inventory of unresolved adolescent conflicts in motherhood

should include conflicts between self-love and love of others. Adolescence is normally a time in which self-love appears in heightened forms. The egocentricity and narcissism of the adolescent are, under all normal circumstances, only headaches that parents and teachers need to live with for a while. But when the adolescent becomes a parent, the self-love and self-centered goals come into conflict with the needs of a baby and the requirements of parenthood. A mother needs to put the child's needs before her own needs, and is able to do this when psychological maturation has given her the possibility of subjugating self-interest and self-love in the interest of a child. The adolescent girl who has not completed this maturational step finds herself strained, or actually incapable, at times, of ministering to the ordinary needs of a helpless baby.

It is this colossal narcissism in the young that evokes anger in the parent generation. When the adolescent is also a mother, the self-centeredness of the mother, united with neglect of her infant, evokes anger in those who are called upon to help her. By the time we met our young mothers, they had been scolded by public health nurses, doctors, and social workers, and grimly prepared themselves for a scolding from us. They seemed surprised, but certainly relieved, when no scolding awaited them.

Narcissism in parenthood, it strikes us, has two faces. There is the self-love that can endanger the child, and there is the self-love that can embrace the child. There is a large measure of

healthy narcissism that goes into the parenting of many good and normal people. The baby is the most remarkable baby in the world. He's a genius, if we have to say it ourselves. Every achievement, even his first tooth, is somehow a credit to us, as parents. All this, the healthy narcissism, is available to the teenage parent, too. We began to see it happen in our work. As the baby began to thrive and reward his mother for her efforts, he became, for his young mother, a marvel, a precocious child, destined for a brilliant future.

From this brief summary, we can see how the intense unresolved conflicts of adolescence become psychological obstacles to the nurturance of a child and may, in fact, provide a theater in which the baby is caught up in the re-evoked childhood griefs and disappointments of the mother. In our group, however, there was still another dimension of conflict which exerted its morbid influence upon the baby, and this was maternal depression.

Six of the eight adolescent mothers were suffering with severe and incapacitating depression. If these girls had not been mothers, they would have required intensive psychotherapy and, in two cases, might have required hospitalization for depression related anorexia. While these young mothers had been labeled by their communities as "rejecting", neglectful, or abusive toward their children, our clinical inquiry led us to understand that these were young girls who were barely able to function. In each case, the depression

had antedated pregnancy and the birth of the child by many months and even years. Since each of these girls had considered the alternatives of abortion and adoption, the decision of these depressed young girls to keep their babies needed to be understood. What did the baby represent? In the course of our work we began to understand. In the hopelessness of depression, the baby represented "hope" and "renewal", the chance to live another life through the baby of fantasy. The hunger for love in the adolescent and the unsatisfied hungers seen in depression found the dream of a baby's love. And not only love, we saw, as we began to unravel the complex meanings of the baby. Periodically, in the course of treatment, the depressed young girl would speak of feelings of emptiness and a yearning for something to fill the emptiness. And, as we moved back into the historical events that had led to pregnancy and the decision to keep the baby, we began to understand. The yearnings for a baby seemed linked to an imperative need "to fill the emptiness."

The baby, being a baby, could not fill the emptiness for needy and hungry girl-mothers. The baby, in fact, was a disappointment. Neither did the baby bring self-renewal or the fulfillment of old dreams. More likely, the bad dreams of childhood were re-evoked by him. The baby had become the center of morbid conflicts by the time we met him.

The Babies: Disorders of Attachment

It's time to talk about the babies. In each of these cases the baby had come to us because of severe disorders of attachment. Here, I am not generalizing to the larger population of infants of teenage mothers. We must remember that, as a psychiatric clinic, we were preselected by referring agencies for our expertise in the area of attachment disorders. The babies, as a group, were among the most severely impaired children in our caseload. They were joyless, listless babies, who showed virtually none of the age-appropriate signs of attachment to their mothers, or who had a limited repertoire of attachment behaviors along with a constricted range of affect. Four of the ten babies were referred to us following diagnosis of failure to thrive.

As we follow the links between the adolescent conflicts of the mothers in our group and the disorders of attachment we identified in their babies, we can see how every component of the unresolved adolescent conflicts became an impediment to the attachment of mother to baby and baby to mother. Where resolution of childhood conflicts paves the way for parenthood and identification with one's own parents, nonresolution brings unreadiness, disappointment, and a turning away from the baby or the investment of the baby with the love-hate conflicts of the mother's own childhood. Where self-love is still dominant in adolescent psychology, there cannot be the selfless love of a parent. And when we add to

this inventory of adolescent afflictions the severe depressions we encountered among the mothers in our group, it appears as if everything in the parental personality is negating the possibility of attachment.

Yet this is by no means a hopeless picture for therapy. Remarkably, when we consider the psychopathology we saw in mothers and babies, we found that we were able to engage each of these mothers in work on behalf of their babies and themselves, and the therapeutic gains were substantial in all but one case.

Clinical Illustration

The case of 16-year-old Karen and her baby, Nina, illustrates many of the interlocking disturbances of mother and baby.¹ It also illustrates our methods of diagnostic study and the formulation of treatment alternatives which grow out of the initial assessment.

No case can stand by itself in illustrating the clinical picture that we saw in our caseload of teenage mothers and their babies. However, the case of Karen and Nina illustrates many of the characteristics of our larger group. Nina, the seven-month-old baby, is referred to us following hospital diagnosis of "non-organic failure to thrive due to maternal deprivation".

At birth, Nina had been a full term healthy baby, birth weight six pounds one ounce (10th percentile) and height was twenty inches (75th percentile). At the time of hospitalization for failure to thrive, Nina's weight had dropped to below the third percentile and

height had fallen to below the 25th percentile. Medical study revealed no organic cause for failure to thrive and the referring pediatrician and nurses concluded that growth failure was caused by severe maternal deprivation.

Her sixteen-year-old mother is unmarried and attending high school. The mother is described as neglectful and unable to cooperate with physicians and nurses who have offered their help. When we meet the mother and baby, we see a young mother who is suffering with a severe depression and a depression-related anorexia which has antedated the birth of the baby by several years. Karen, the mother, weighs approximately eighty-five pounds. Food is repulsive to her, she tells us, and she eats barely enough for sustenance. She knows the doctors are concerned about Nina, but she is not sure why. Nina looks chubby to her, she says.

Karen and Nina are supported by AFDC. They are living in the home of the maternal grandparents in the midst of domestic chaos. There are violent quarrels between Karen's mother and father, periodic separations. Karen and Nina are given grudging shelter in this home. Nina is unwanted. Karen is taunted daily by her parents for bringing a baby into this home. No help is offered Karen. Karen would like to find another place to live. But she is afraid to live alone. What is she afraid of? "Of noises. Animals. Burglars." She is a child herself, of course. The grandparents themselves are hostile to the treatment offered

Karen and Nina. They will not permit us to visit the home. If Karen wants our help she will have to see us at our office. With all these constraints we will need to provide treatment for this endangered baby and her mother.

In the course of the initial evaluation period, we are asking ourselves many questions. The developmental testing of Nina will give us a fair assessment of the motor and cognitive development of Nina and the areas of deficit, if they exist. But the test will not help us to discern the qualities of infant-mother relationship. In our observations, we want to look for the age-appropriate indicators of human attachment in the baby, and the ability of the mother to respond to the range of signs and signals which a baby can send to the mother, and the ability of the mother to initiate and exchange social and affectionate signs with her baby.

In our initial observations we see a severely depressed young mother and her child who is suffering from growth failure and a severe attachment disorder. The depression of the mother is mirrored in the baby's face. The baby is silent, stares off into space, uninvested in her surroundings. She rarely turns to her mother for a social exchange or for comfort. In our broader observations, we see a limited number of attachment indicators. There is discrimination of her mother from others, there is preference for her mother. Nina has a limited repertoire of attachment behaviors, but they are muted and joyless. Similarly, Karen shows some signs

of affection for her baby, but she sinks back into depression and solitude after each exertion.

As we look at the depressed and anorectic mother, we also look at our own therapeutic dilemma. Karen cannot read the signs of hunger and satiation in herself; how can she read the signs of hunger and satiation in her baby? In fact, in every observation during this assessment period of seven sessions, Karen seems unable to read hunger in Nina, or misreads the signs.

Ideally, we would want our therapy to focus on the interlocking aspects of Karen's depression and her baby's attachment disorder. But soon after treatment begins, we find ourselves facing a formidable therapeutic problem. If the therapist begins to speak about feelings with Karen, to speak of sadness or anger, to touch ever so gently upon the defenses against affect, Karen's depression deepens and her symptoms are exacerbated.

Clearly, we cannot yet deal with Karen's internal and objective conflicts without precipitating a grave conflict in personality, and worsening the situation for Karen and Nina. We decide, then, that we will work with Karen and Nina, for the indefinite future, within the context of supportive treatment and developmental guidance. This treatment brings about very substantial changes for Karen and Nina.

Our treatment focused on both the nutritional and psychological aspects of Nina's and Karen's interlocking conflicts.

But both aspects of this treatment were solidly embedded in the context of human attachments. On the nutritional side, we worked with Karen and the nursery in providing an optimal diet for Nina. Karen and the nursery staff were helped to see how a baby's pleasure in eating was intimately related to pleasure in the arms of a partner, most particularly the mother. Karen was encouraged to take over the lunch feedings in the nursery as often as possible. One (or at most, two) aides at the nursery was assigned as Nina's special caregiver.

In our own sessions with Karen and Nina and the therapist together in our playroom, the therapist focused on the relationship between Nina and Karen, emphasizing in every way possible how Karen was the most important person in the world to her baby, how no one, not the therapist either, could get the special smiles from Nina, and no one could comfort Nina in distress as well as her mother could. Karen, who had never in her life believed she was important or special to anyone, was deeply touched as she learned to recognize these signs of preference and love in her baby. And Nina, like all babies, gave generous rewards to her mother. Within four months of work, Nina made tremendous progress toward nutritional adequacy and psychological adequacy.

Karen, watching the therapist talk to Nina, was initially puzzled. After all, Nina could not understand English. Karen had no traditions in her family for talking to a baby, or indeed, for

conferring personality upon a baby. As Karen watched her therapist, she saw that Nina began to make responsive sounds, and it was easy for the therapist to begin to speak about how babies learn to talk. Within a short time, mother-baby dialogues appeared in all of our sessions, and the quiet baby who never uttered a sound became positively gregarious.

Karen's conflicts with her own parents gave her no models for parenting. Her own mother did not like babies and considered a baby who cried as "just plain spoiled". Her own mother did not believe that a baby of Nina's age cared who took care of her. Mothers were not important. Karen's therapist listened to Karen and listened to Nina with most respectful attention to each. To understand why Nina cried, or what Nina was trying to tell us, became central to every session. To understand Karen's sadness, Karen's inarticulate cries and griefs, were equally central to the sessions. Karen was profoundly touched by her therapist's concern for her, her listening, her sympathy, her praise, and her confidence in Karen. No one had ever cared for her in this way. Later she told the therapist how much this caring had meant to her. Karen, whose own griefs were listened to, became a mother who could listen, in every sense of the word, to her child's cries and the everyday griefs of a small girl. She began to understand Nina's pain at separation from her each day at the door of the nursery. She had no alternatives in care for Nina but she could

now find words of sympathy and understanding for Nina which made the pain bearable. In short, what Karen received in emotional sustenance from her therapist, she could now give to her own baby.

At fourteen months of age, Nina had reached weight adequacy and adequacy in our affective-social evaluation. She had also made substantial gains in cognitive motor development.

Our health evaluation showed that Nina had gained weight steadily in these seven months of work. Her weight was now nineteen pounds which placed her between the tenth and twenty-fifth percentile. She was bright eyed, animated, strong, active, had good color and muscle tone. (She sustained these gains in later years.)

In the affective-social areas which had been seriously affected by the time we first met her at seven months, Nina was now age adequate. She had a good range of affective expression. She had strong and stable ties to her mother, with strong preference for and valuation of her mother (as we saw in social situations as well as need states). Her pleasure in being with her mother was manifest through warm and special smiles for her mother, animated "conversations" with her mother, seeking her mother to share ^{special} moments and to touch base with her. She showed age appropriate reactions to the daily separations from her mother at the nursery. She protested, then settled down (with resignation) to the less than ideal circumstances provided by this substitute

care.

There were advances in cognitive motor development. At fourteen months she scored an MDI on the Bayley of 133. Her first testing at seven months had actually placed her within normal range (110), but now we could see that Nin's potential in mental development was higher than average. The gains reflected to some measure the tremendous progress in language development which was one result of our work.

During this period there was one developmental problem that needed our special attention. Nina would waken briefly at night wanting "to play" with her mother. We were not certain of the meaning of this night waking. Was this associated with the painful separations from mother at the nursery? Was she also napping for many hours during the nursery day? We could not be sure. And the nursery had no information, no records. While we were still trying to understand this, the night waking disappeared. We have no further information.

During this period we saw Karen develop into a responsible and affectionate mother. As I illustrate, it is important to keep in mind that Karen was still a seriously depressed girl and was still anorectic.

We had already discovered that our treatment of Karen had to be modified because of her inability to tolerate exploration of her profound conflicts (mainly internalized rage). She could

not tolerate even the gentlest therapeutic probing of her feelings toward her mother and father, yet found comfort in the understanding and sympathy which the therapist expressed as she listened to the reports of fights between the maternal grandparents, their constant blame of Karen for bringing a baby into this home, their depreciation of Karen as mother.

Our work, then, with Karen was mainly supportive and the supportive work was united with observations of Nina and developmental guidance. All of this brought significant developmental progress for Nina as we have seen. And for Karen, too, there was brightening of mood, enhancement of self-image, new confidence in herself as a mother. But the anorexia remained. Karen could now feed her baby, but she could not feed herself.

In describing the therapeutic approach to Karen, I should say that I am not generalizing about work with adolescents or work with adolescent parents. In nearly every other case we have worked with we were able to deal therapeutically with the inner conflicts of our adolescent parents, and to do this fairly early in treatment. Only in Karen's case was such an approach contraindicated.

Actually, we had to wait two more years before Karen's love-hate conflicts toward her parents could be dealt with therapeutically (and, I believe, with great benefit to her). But what we learn from this work is that long before the clinical picture

of a mother's disorder can change, there are large possibilities for change in the capacity to mother which can be brought about through supportive treatment and guidance.

Between Nina's age fourteen months and twenty-two months, we continued to work with mother and baby. For Nina, all gains in health, affective and cognitive development were sustained.

At twenty-two months, Nina was a healthy, enthusiastic, buoyant, outgoing child. In nursery school (a new school) she was regarded by her teachers as intelligent, creative, socially mature for her age. She was well liked by her teachers and her peers.

In doll play in our observation sessions we saw Nina as a tender and solicitous mother. She loved "feeding" and "cooking" for her dolls. We could not see residues of early oral conflicts.

Karen, herself, was a proud mother. Through guidance she had become a very sensitive and empathic reader of signs and needs in her child. She enjoyed Nina. She was proud of her spunkiness and assertiveness (a vicarious pleasure for a young woman now eighteen years old, who could not yet assert herself with her own parents, except in defending Nina). Some measure of Karen's self-confidence was brought to improved school work and a decision to enroll in a community college after high school graduation.

It was not until the final year of treatment when Nina was

three years old that Karen's profound conflicts which centered in the relationship to her own parents, could be dealt with. At last she felt strong enough as a person to allow herself to feel rage and disappointment toward her own parents, to speak of the heartbreaks, the childhood sense of worthlessness, the fear of parental explosions. The depression lifted. The last vestiges of anorexia disappeared.

Karen's joy in her child had been sustained through our work. But now there was the beginning of pleasure for herself.

Karen, at last, was ready to move out of her parental home. She made good plans for herself and Nina and entered a community college technical training program. With the liberation from parental love-hate bonds, Karen fell in love with a stable young man who became devoted to her and to Nina. Within a year after termination of treatment they were married.

Discussion

A single case of an adolescent mother and her baby cannot, of course, illustrate all of the factors which I have identified early in this paper as characteristics of the unresolved conflicts of adolescence which impinge upon motherhood.

What we can see in the case of Karen and Nina are the effects of profound inner conflicts in adolescence upon the capacity to mother a baby. Karen, when we meet her, is a child, herself, caught in a morbid love-hate conflict with her own parents. Her

depression and anorexia speak for intense internalized rage toward her own parents. The unsatisfied longings and hungers of adolescence had led her to early sexual experience with boys in casual encounters. She became pregnant. And she wanted to keep her baby. When we first met Karen and Nina we saw a starving mother and a starving baby living in the home in which Karen's family gave grudging shelter and neither affection nor support to their child or their grandchild. If we give clinical attention to Karen's own adolescent conflicts (imagining for a moment that she does not have a baby) the therapeutic task appears a formidable one. The anorexia is severe enough to warrant hospitalization. Depression has depleted Karen's resources. She is barely able to function in school. Failures in love have marked her life from childhood to adolescence, now marked again by the failures in seeking love from boys. There are unresolved oedipal problems in the pursuit of "forbidden love" through transient boys.

But this adolescent, with some ordinary and many extraordinary developmental problems, is a mother. And her baby is in great danger.

Anorexia has distorted Karen's ability to read her own signs of hunger and satiation. Anorexia has blotted out her recognition of hunger and satiation in her infant. Depression, which makes her psychologically "absent" in all social relationships, has made

her psychologically absent to a baby who is most imperatively in need of mother nurture.

The baby, herself, seems not quite real to Karen when we first meet her. She is uncertainly a mother. She still needs a mother herself. Her own longings for nurture collide at times with the baby's needs for nurture. And the fantasy baby who would satisfy longings to be loved, and the yearning for self-renewal which are universal in adolescence, is afterall only a baby with imperative demands, and no promise of bringing self-renewal. The baby of fantasy who would "fill the emptiness" only enlarges the sense of emptiness. At best, if Karen summons all of her meager resources, she can give mechanical care to Nina.

And Karen has no models for mothering. Her own mother's failure to mother leaves Karen bereft of knowledge and tradition.

We can sketch the treatment for Karen if Karen were not a mother. Many months of intensive work would be required. Hospitalization of Karen might be desirable. But Nina, the baby is our patient, too. She cannot wait for her mother's depression to lift, or for resolution of the complex problems that are bound together in anorexia.

Our work with Karen and Nina focused on the needs of both the baby and the mother. It was a delicate balance to sustain, for Karen, like many adolescent mothers we know, was desperately needy herself. The largest number of sessions were held with both mother

and baby in the room. When necessary, private sessions for Karen, herself, were arranged.

Psychotherapy is a form of undoing of the past. And so it was for Karen, too, even though our access to the emotionally laden memories of the past was limited by Karen's own defenses against powerful affects. Where rejection by parents had led to Karen's feelings of worthlessness, the relationship to the therapist could give to Karen a sense of worth as an adolescent, and as a mother. Where unsatisfied longings for mother-love had led to morbid symptoms, therapy could provide a form of psychological nurturance which sustained the adolescent girl and had the effect, I think, of undoing some part of the injuries of the past. Where failures in understanding had marked the relationship with parents, understanding and profound sympathy from a therapist had the effect of healing the old wounds. Where the baby was somehow "a child of sin" with echoes from an unremembered past, and censorship from the maternal parents, the baby was given, through our work, the rights of every baby to be cherished and to bear no shameful stigma.

Where the baby was uncertainly a fantasy baby, who belonged to an oedipal romance, we helped to make the baby a real baby, a real person, which had the effect of detaching the baby from childhood conflicts even though we were unable to deal with those fantasies directly. And long before we were able to deal with the inner conflicts of Karen in our treatment, Nina, herself, began

to fulfill her mother's adolescent dream of renewal of self, a rebirth through giving birth to a child. Nina, through our work, became a loving intelligent, social little person who gave her mother huge rewards for motherhood. The mother who could not love herself or value herself when we first met her could know love and valuation from her child. Some measure of self-love could now grow in Karen, which means of course, that for Karen, as well as all parents, a loving and rewarding child brought enhancement of self-love, the healthy narcissism that is the privilege of all parents.

Nina's progress in treatment was far in advance of her mother's during the first two years. Nina was brought to adequacy on all measures of personality development by the time she was fourteen months old. But in this work we have two patients, a mother and a baby. As long as Karen's depression remained Nina was regarded by us as at risk and her mother's psychological state was regarded as precarious. When treatment was terminated at Nina's age three and a half, we were satisfied that Karen's internal conflicts had found resolutions and that Nina was sturdily progressing in her own development.

Therapeutic work with adolescent mothers and their babies needs to accomodate objectives for the treatment of two patients, each of whom may be suffering from a developmental disorder. This therapy has the aim of bringing optimal development for an adoles-

cent who is also an adolescent mother and for a baby whose development is endangered.

Notes

1. A full clinical report of this case and three other cases of adolescent mothers are included in Selma Fraiberg, editor, Clinical Studies in Infant Mental Health: The First Year of Life, Basic Books, Inc., New York, 1980.

Information About the Author

Selma Fraiberg

Professor of Child Psychoanalysis

Director of Infant-Parent Program

University of California, San Francisco

~~Adolescent~~
THE ~~TEENAGE~~ MOTHER AND HER INFANT

Selma Fraiberg

this paper
In ~~my presentation this morning~~ I will describe our work with adolescent mothers and their infants in an infant psychiatry program. In the first part of this paper I have gathered together some of our clinical observations of a group of young mothers struggling with formidable developmental conflicts of adolescence and their new and uncertain identity as mother to an infant. In the second part of the presentation, I will describe our treatment of one 16-year-old, severely depressed mother and her failure to thrive infant ~~and use video clips to illustrate the progress of mother and baby in the course of therapy.~~

16
16

As the basis for this presentation I have chosen a group of 10 babies and their ~~eight~~ ⁸ adolescent mothers who constituted a subgroup in our intensive treatment caseload in our University of Michigan program ^{during the period Nov. 1972 + October 1978.} The 10 babies represented ~~nearly~~ 20% of our intensive treatment caseload of 50. Since the only criteria for entering our intensive treatment program were our assessment of need for this form of treatment and the practical limitations of a small staff, it is important to note that teenage mothers constituted a substantial part of a group identified by us as gravely incapacitated in functioning, and their babies constituted a substantial number of those we had identified as severely impaired in critical areas of functioning.

note & myself.
N is present - checked test of Judy's sample description

- More?
1. Professor of Child Psychology
Director of Infant - Parent Program
University of California San Francisco

Characteristics of the Group:

The ages of the mothers at the time of delivery ranged from 16 to 18. Five were unmarried girls. Of the four mothers who were married, one was separated from her husband. The five fathers in the never-married group are unknown to us, and in fact, broke connections with the girl soon after pregnancy was confirmed. They appear in our records as nameless and faceless, and in each case were partners in casual encounters.

Seven of the ¹⁰_n babies were firstborn ~~(including one set of twins)~~. ~~One in the married group was a second child.~~ All of the babies were full term with birth weights within the normal range. Congenital defects were later identified in three of the children. ~~(The data summarized here will be presented on slides)~~ All of the mothers were living in poverty. The five unmarried mothers were supported by AFDC. In nearly all cases the young mother was living apart from her family of origin, and encounters with the extended family were caught up in conflict and turmoil. There were neither psychological support for mother and baby nor traditions of childrearing to guide a young girl who was unready for motherhood.

The five unmarried mothers were attending school or were enrolled in job training. Their babies were being cared for in day-care centers or family day-care. Mainly, the day-care arrangements, which we ourselves could assess through visiting, were poor, and offered little more than custodial care. In three cases there was outright neglect of infants. As we came to know the babies and their families, we were sobered by the

fact that the child, endangered by the considerable pathology in the mother, and already showing signs of a severe attachment disorder, was further endangered by the circumstances in which he received indifferent or neglectful substitute mother care. The baby who needed an optimal day-care program was receiving substitute care of the poorest quality.

The babies and their mothers had been referred to us by physicians, nurses and social workers in Wasthenaw County (population approximately 300,000). The babies of teenage mothers were, as a group, among the most severely impaired children in our caseload. A primary attachment disorder was present at the time of referral in each case. Four of the babies had been hospitalized for failure to thrive. The teenage mothers, as a group, showed grave impairment in psychological functioning and were virtually incapacitated in mothering a baby. Although they had been labeled by their community as "neglectful" and "rejecting," none of them had been evaluated by a psychiatric team until they came into our program. Ideally, we would like to see a psychosocial assessment of the teenage mother in every case, at the point where the pregnant girl is first identified by the health provider. After our own diagnostic study, ⁸ six of the ⁿ mothers were seen by us as severely depressed. Depression in each of these cases had been present for many months and even years before the baby was conceived. In fact, as I shall later discuss, depression and the unsatisfied psychological hungers which were entwined with depression, had found their way into longing for a baby.

Developmental Conflicts of Adolescence and Motherhood

When I speak, now, of the interlocking development conflicts of adolescence and motherhood which we saw in this group of young girls, I should preface these remarks with some caution. Clearly, the group of severely disordered teenage mothers in our caseload do not represent the larger population of teenage mothers, in which we can find a fair amount of adequate or excellent mothering. And when I describe the adolescent conflicts and mothering conflicts which we encountered, they are not typical, I feel, but are exaggerated and heightened conflicts, in which universal problems of adolescent maturation have become distorted by disorder in the adolescent personality and the inability of the primary family of the girl to provide the vital pathways to resolution of conflict. The girl and her family, in our cases, were locked together in a morbid conflict.

The diagnostic study and treatment of this group of young mothers and their infants brought into focus the interlocking conflicts of adolescent development and mother-infant relationships. Each of these mothers had become pregnant at a point in psychological development when attachment and detachment from the primary family figures had produced conflicts of considerable magnitude. The unresolved conflicts of adolescence became the focus of new conflicts which embraced the child. The attachment and detachment problems of the mother were mirrored in the disorders of attachment which we saw in the baby.

The baby was caught up in the morbid past and uncertain present of his mother, but he was also most poignantly the

symbol of hope and self-renewal in his mother. Each of the unmarried girls, it should be noted, had examined the alternatives of abortion and adoption, and had chosen to keep the baby. They wanted their babies and kept them against the wishes of their own parents. In each case, the baby, when we met him, was manifestly neglected and showed impoverishment in all areas of human attachment. The contradiction between the adolescent mother's daydreams for the baby and the actual state of the baby needed to be understood.

As we came to know these adolescent mothers, we saw how many of the typical conflicts of adolescence had become intensified and magnified for each of these girls before they became pregnant. Their own mothers were at the center of these conflicts, and by the time we came to know them, these conflicts appeared to consume the life energies of each. In normal adolescence we may see the love-hate conflicts of the girl surface in daily life, but after the storm the beloved aspects of the mother can be reclaimed. What is preserved and eventually consolidated in the course of adolescence becomes available for positive identification and integration of personality in late adolescence. But among the young girls in our group, the mother as enemy and betrayer dominated the theater of conflict, and there appeared to be no aspect of this mother that could serve maturation and identification. It also seemed to us that the mothers of these girls had become the unwitting collaborators in this tense family drama, transforming themselves into the enemy, so that the fantasy mother and the real mother sometimes merged.

Side by side with these consuming struggles with the mother was dependency in the girl and a longing for nurturance from the mother, which was explicitly brought to us in their stories and re-enacted in transference with the therapist. Often, when the therapist was visiting the young mother and her baby in the home, there were two crying children in that living room.

The unresolved mother conflicts of the girl became impediments to mothering and to the attachment of the girl to her baby. A girl who is fighting against her tie to her mother, who sees her mother as an enemy without redeeming features, has nothing good or solid to hold onto when she seeks a model for herself as mother. And a girl who is still longing for a mother, who wants a mother to hold her close, nourish her, is not ready to become a mother herself.

Much of the important work that we accomplished in our treatment of these teenage mothers grew out of our exploration of the mother conflicts which were paralyzing the girl in her own psychological development. We examined the love-hate relationship to the mother, as they were described to us and as they were re-enacted in transference to the therapist. We provided, through our treatment, a form of psychological nurturance for hungry girls. We offered a relationship in which independence could grow out of dependency, and affection and trust for the therapist could provide the conditions for new identifications with an adult figure and alternative models for mothering. The listening and understanding which the therapist gave the young mother could be transformed into listening to and understanding of a baby. Again and again, in our records, the therapist is in

a room with a crying mother and a neglected and crying baby, and the therapist offers words of comfort to the mother and the mother turns to the crying baby as if she has heard him for the first time.

✓ The adolescent girl's father, as he was described to us and revealed through the eyes of the girl, was also at the center of love-hate conflicts. We ~~would~~ expect that in the normal adolescent process the girl's attachment to her father is gradually modified, that the oedipal wishes and fantasies are transformed and that resolution paves the way to the discovery of new partners in love. Among the adolescent mothers in our group, the childhood daydream of father-love had been preserved and was re-enacted with male partners who appeared as transient lovers - if, indeed, the word "lovers" should be used.

Since the attachment to the father was ^{still primary} preserved, there was no possibility of forming an enduring bond with another male partner. Typically among our girls, sexually activity had begun at the age of 13 or 14. The sexual partners were distantly remembered and seemed to have no more substantiality than figures in a fantasy. And, in fact, the sexual experiences resembled fantasies in which each partner was interchangeable with the other, like the masturbation fantasies of early adolescence. What was acted out in these transient sexual episodes was the fantasy of forbidden and dangerous love, a transparent oedipal fantasy. When pregnancy occurred, the unconscious childhood fantasy of having a baby with the father added another psychological dimension to a crisis, and the baby,

when he arrived, became the embodiment of a shameful secret, a "child of sin", in the old-fashioned phrase.

The baby was also the child of a profound disappointment, the result of a promise that was not kept by whoever it is in our society who makes promises to the young. In the hyped-up sexual climate~~d~~ of our times, it is easy for the young to believe that puberty carries a passport into sexual bliss. But not one of the young girls in our group had experienced sexual ^{pleasure} joy of any kind in their many encounters. In fact, the serial encounters were motivated by the search for sexual joy. "It'll be different with the next ^{fellow} ~~one~~." But it never was. These girls were, in fact, unready for sexual fulfillment, like the majority of adolescents in their early and mid-teens. But clearly, ~~or~~ ^{for} the girl we are speaking of, a girl who is still pursuing a childhood fantasy love with her father, there is no place yet for a new partner and uninhibited sexual joy. The father-love becomes the inhibitor.

The father-love also becomes an impediment to motherhood. A girl who is still playing out an unconscious childhood fantasy of make-believe love and make-believe union with her father is ~~unlikely~~ to continue this fantasy as a make-believe mother with a make-believe baby. And this, in fact, is what we saw when we first met the mothers and babies in our group. Motherhood was somehow unreal. The baby was not quite real.

In our infant-focused psychotherapy we listened to the tangled stories of fathers and lovers, and helped the adolescent mother to find new solutions to old griefs and old longings. As we watched the mother and her baby together in session after session, we were attentive to those aspects of the baby and of mothering which were caught up in the old daydream. Where the baby was somehow unreal, and motherhood was unreal, we could make them real. This was not a fantasy baby to us; he was a person with all the unique qualities of his own personality. She was not a pretend mother, to us; she was a real mother with real concerns for her baby and real problems. We played with this real baby and revealed his marvelous attributes to his mother. We talked to the real mother and most respectfully gave her the authority and the prestige of mother. She was not a child to us, innocent and blundering, but a mother trying very hard to be a mother in the midst of terrible hardship.

The unresolved conflicts of childhood embraced every aspect of the childhood family. Repeatedly, in our work with adolescent mothers, we saw intense sibling conflicts re-enacted with the baby. Jealousy toward the baby, competition with the baby, anger toward the baby, the feeling of being robbed of something precious by the baby, were recurring themes which we could trace back in treatment to a sibling who had been a rival in childhood. Normally, in adolescence, the sibling conflicts of childhood undergo resolution along with other

early and intense love-hate relationships of the family. When the adolescent process has not been completed through maturation, the old jealousies and hostilities stand ready for transference to other objects. Tragically, in the case of teenage motherhood, the new baby may come to represent the old rivals in the family of childhood.

In our work with the adolescent mother, we examined those ways in which the baby was caught up in old memories and the conflicts of the childhood family of the mother. We helped the mother to disentangle her baby from the figures of childhood and free the baby from the ghosts in the maternal past.

The inventory of unresolved adolescent conflicts in motherhood should include conflicts between self-love and love of others. Adolescence is normally a time in which self-love appears in heightened forms. The egocentricity and narcissism of the adolescent are, under all normal circumstances, only headaches that parents and teachers need to live with for a while. But when the adolescent becomes a parent, the self-love and self-centered goals come into conflict with the needs of a baby and the requirements of parenthood. A mother needs to put the child's needs before her own needs, and is able to do this when psychological maturation has given her the possibility of subjugating self-interest and self-love in the interest of a child. The adolescent girl who has not completed this maturational step finds herself strained, or actually incapable, at times, of ministering to the ordinary needs of a helpless baby.

It is this colossal narcissism in the young that evokes anger in the parent generation. When the adolescent is also a mother, the self-centeredness of the mother, united with neglect of her infant, evokes anger in those who are called upon to help her. By the time we met our young mothers, they had been scolded by public health nurses, doctors, and social workers, and grimly prepared themselves for a scolding from us. They seemed surprised, but certainly relieved, when no scolding awaited them.

Narcissism in parenthood, it strikes us, has two faces. There is the self-love that can endanger the child, and there is the self-love that can embrace the child. There is a large measure of healthy narcissism that goes into the parenting of many good and normal people. The baby is the most remarkable baby in the world. He's a genius, if we have to say it ourselves. Every achievement, even his first tooth, is somehow a credit to us, as parents. All this, the healthy narcissism, is available to the teenage parent, too. We began to see it happen in our work. As the baby began to thrive and reward his mother for her efforts, he became, for his young mother, a marvel, a precocious child, destined for a brilliant future.

From this brief summary, we can see how the intense unresolved conflicts of adolescence become psychological obstacles to the nurturance of a child and may, in fact, provide a theater in which the baby is caught up in the re-evoked childhood griefs and disappointments of the mother. In our group, however, there was still another dimension of conflict

which exerted its morbid influence upon the baby, and this was maternal depression.

Number 228
Six of the ~~nine~~⁸ adolescent mothers were suffering with severe and incapacitating depression. If these girls had not been mothers, they would have required intensive psychotherapy and, in two cases, might have required hospitalization for depression related anorexia. While these young mothers had been labeled by their communities as "rejecting," neglectful, or abusive toward their children, our clinical inquiry led us to understand that these were young girls who were barely able to function. In each case, the depression had antedated pregnancy and the birth of the child by many months and even years.

Since each of these girls had considered the alternatives of abortion and adoption, the decision of these depressed young girls to keep their babies needed to be understood. What did the baby represent? In the course of our work we began to understand. In the hopelessness of depression, the baby represented "hope" and "renewal," the chance to live another life through the baby of fantasy. The hunger for love in the adolescent and the unsatisfied hungers seen in depression found the dream of a baby's love. And not only love, we saw, as we began to unravel the complex meanings of the baby. Periodically, in the course of treatment, the depressed young girl would speak of feelings of emptiness and a yearning for something to fill the emptiness. And, as we moved back into the historical events that had led to pregnancy and the decision to keep the baby,

we began to understand. The yearnings for a baby seemed linked to an imperative need "to fill the emptiness."

The baby, being a baby, could not fill the emptiness for needy and hungry girl-mothers. The baby, in fact, was a disappointment. Neither did the baby bring self-renewal or the fulfillment of old dreams. More likely, the bad dreams of childhood were re-evoked by him. The baby had ~~become~~^{become} the center of morbid conflicts, by the time we met him.

The Babies: Disorders of Attachment

It's time to talk about the babies. In each of these cases the baby had come to us because of severe disorders of attachment. Here, I am not generalizing to the larger population of infants of teenage mothers. We must remember that, as a psychiatric clinic, we were preselected by referring agencies for our expertise in the area of attachment disorders. The babies, as a group, were among the most severely impaired children in our caseload. They were joyless, listless babies, who showed virtually none of the age-appropriate signs of attachment to their mothers, or who had a limited repertoire of attachment behaviors along with a constricted range of affect. Four of the ¹⁰~~eleven~~ babies were referred to us following diagnosis of failure to thrive.

As we follow the links between the adolescent conflicts of the mothers in our group and the disorders of attachment we identified in their babies, we can see how every component of

the unresolved adolescent conflicts became an impediment to the attachment of mother to baby and baby to mother. Where resolution of childhood conflicts paves the way for parenthood and identification with one's own parents, nonresolution brings unreadiness, disappointment, and a turning away from the baby or the investment of the baby with the love-hate conflicts of the mother's own childhood. Where self-love is still dominant in adolescent psychology, there cannot be the selfless love of a parent. And when we add to this inventory of adolescent afflictions the severe depressions we encountered among the mothers in our group, it appears as if everything in the parental personality is negating the possibility of attachment.

✓ Yet this is by no means a hopeless picture for therapy. Remarkably, when we consider the psychopathology we saw in mothers and babies, we found that we were able to engage each of these mothers in work on behalf of their babies and themselves, and the therapeutic gains were substantial in all but one case.

Illustration
CLINICAL ~~PRESENTATION~~

In the second half of my presentation, I will describe our work with one mother and her baby. The case of 16-year-old Karen and her baby, Nina, illustrates many of the interlocking disturbances of mother and baby.* It also illustrates our

Footnote * A full clinical report of this case and 3 other cases of adolescent mothers are ^{other} included in Fraiberg ed. Clinical Studies in Infant Mental Health - its history & future

Karen and Nina are supported by AFDC. They are living in the home of the maternal grandparents ~~in the--in~~ the midst of ~~much-d-~~ domestic chaos ~~caused-by-viol-~~ and There are violent quarrels between Karen's mother and father/ periodic separations. Karen and Nina are given grudging shelter in this home. Nina is unwanted. Karen is taunted daily by her parents for bringing a baby into this home. No help is offered Karen. Karen would like to find another place to live. But she is afraid to live alone. What is she afraid of? Of- "Of noises. Bug- Animals. Burglars." She is a child, herself, of course. The grandparents themselves are hostile to the treatment offered Karen and Nina. They will not permit us to visit the home. ~~The-work-~~ ~~must-be-carried~~ If Karen wants our help she will have to see us at our office. With all these constraints we will need to ~~pre-~~ provide treatment for this endangered baby and her mother.

methods of diagnostic study and the formulation of treatment alternatives which grow out of the initial assessment.

No case can stand by itself in illustrating the clinical picture that we saw in our caseload of teenage mothers and their babies. However, the case of Karen and Nina illustrates many of the characteristics of our larger group. Nina, the seven-month-old baby, is referred to us following hospital diagnosis of "non-organic failure to thrive" due to maternal deprivation. ^{Insert} Her 16-year-old mother is unmarried and attending high school. The mother is described as neglectful and unable to cooperate with physicians and nurses who have offered their help. When we meet the mother and baby, we see a young mother who is suffering with a severe depression and a depression-related anorexia which has antedated the birth of the baby by several years. Karen, the mother, weighs approximately 85 pounds. Food is repulsive to her, she tells us, and she eats barely enough for sustenance. She knows the doctors are concerned about Nina, but she is not sure why. Nina looks chubby to her, she says.

In the first set of tape excerpts we see Karen and Nina together during developmental testing and a brief play period. We customarily videotape our developmental testing session, but we do not videotape our interviews and we do not invite confidential material from the mother during the videotaped sessions. The videotaped observations help us and the mother to observe the baby and to examine, in fine detail, the interactions between mother and child.

*
Insert p; 15

Mema--

At birth, Nina had been a full term healthy baby, birth weight six pounds one ounce (10th percentile) and height was twenty inches (75th percentile). At ~~referral~~ the time of hospitalization for failure to thrive Nina's weight had dropped to below the third percentile and height had fallen to below the 25th percentile. Medical study revealed no organic cause for failure to thrive and the ~~consensus~~-- referring pediatrician and nurses concluded that growth failure was caused by severe maternal deprivation.

-Karen-the-mother--

Karen, her 16 year old mother is unmarried and attending high school. (Debby, continue on with old text.

initial evaluation period.
In the course of the ~~videotaped session~~, we are asking ourselves many questions. The ~~Bayley~~ *developmental of Nina* testing will give us a fair assessment of the motor and cognitive development of Nina and the areas of deficit, if they exist. But the test will not help us to discern the qualities of infant-mother relationship. *In our observations* During the ~~testing~~, we ~~will~~ want to look for the age-appropriate indicators of human attachment in the baby, and the ability of the mother to respond to the range of signs and signals which a baby can send to the mother, and the ability of the mother to initiate and exchange social and affectionate signs with her baby.

TAPE ON. NINA AT 7 MONTHS OF AGE

TAPE OFF. NINA AT 11 MONTHS OF AGE

~~NARRATION.~~

~~This tape story will continue very shortly, and we will see Nina and Karen at two later intervals of treatment: at 14 months and 26 months. We will interrupt them because this seems a good point to discuss the diagnostic problems which emerged in the early stages of our work and the treatment considerations which grew out of them.~~

In our initial observations we see a
We have seen a severely depressed young mother and her child who is suffering from growth failure and a severe attachment disorder. The depression of the mother is mirrored in the baby's face. The baby is silent, stares off into space, uninvested in her surroundings. She rarely turns to her mother

for a social exchange or for comfort. In our broader observations, ~~off tape~~, we see a limited number of attachment indicators. There is discrimination of her mother from others, there is preference for her mother. Nina has a limited repertoire of attachment behaviors, but they are muted and joyless. Similarly, Karen shows some signs of affection for her baby, but she sinks back into depression and solitude after each exertion.

As we look at the depressed and anorexic mother, we also look at our own therapeutic dilemma. Karen cannot read the signs of hunger and satiation in herself; how can she read the signs of hunger and satiation in her baby? In fact, in every observation *during this assessment period of 7 sessions* outside of this ~~tape~~, Karen seems unable to read hunger in Nina, or misreads the signs.

Ideally, we would want our therapy to focus on the interlocking aspects of Karen's depression and her baby's attachment disorder. But soon after treatment begins, we find ourselves facing a formidable therapeutic problem. If the therapist begins to speak about feelings with Karen, to speak of sadness or anger, to touch ever so gently upon the defenses against affect, Karen's depression deepens^s and her symptoms are exacerbated. *the grandparents' refusal to be involved in treatment prevents us from dealing* Nor can we deal with the chaos in Karen's parents' home. *The grandparents refuse to see us. They don't* trust psychologists and will not allow us to enter the home. Karen can see us at the office with their grudging consent.

Clearly, we cannot yet deal with Karen's internal and objective conflicts without precipitating a grave conflict in

personality, and worsening the situation for Karen and Nina. We decide, then, that we will work with Karen and Nina, for the indefinite future, within the context of supportive treatment and developmental guidance. This treatment brings about very substantial changes for Karen and Nina ~~which we will see in our later tapes.~~

Our treatment focused on both the nutritional and psychological aspects of Nina's and Karen's interlocking conflicts. But both aspects of this treatment were solidly embedded in the context of human attachments. On the nutritional side, we worked with Karen and the nursery in providing an optimal diet for Nina. Karen and the nursery staff were helped to see how a baby's pleasure in eating was intimately related to pleasure in the arms of a partner, most particularly the mother. Karen was encouraged to take over the lunch feedings in the nursery as often as possible. One (or at most, two) aides at the nursery was assigned as Nina's special caregiver.

In our own sessions with Karen and Nina and the therapist together in our playroom, the therapist focused on the relationship between Nina and Karen, emphasizing in every way possible how Karen was the most important person in the world to her baby, how no one, not the therapist either, could get the special smiles from Nina, and no one could comfort Nina in distress as well as her mother could. Karen, who had never in her life believed she was important or special to anyone, was deeply touched as she learned to recognize these signs of preference

and love in her baby. And Nina, like all babies, gave generous rewards to her mother. Within four months of work, Nina made tremendous progress toward nutritional adequacy and psychological adequacy.

Karen, watching the therapist talk to Nina, was initially puzzled. After all, Nina could not understand English. Karen had no traditions in her family for talking to a baby, or indeed, for ~~conferring~~ personality upon a baby. As Karen watched her therapist, she saw that Nina began to make responsive sounds, and it was easy for the therapist to begin to speak about how babies learn to talk. Within a short time, mother-baby dialogues appeared in all of our sessions, and the quiet baby who never uttered a sound became ~~more talkative~~. *continually gurgulous (sp.)*

Karen's conflicts with her own parents gave her no models for parenting. Her own mother did not like babies and considered a baby who cried as "just plain spoiled." Her own mother did not believe that a baby of Nina's age cared who took care of her. Mothers were not important. Karen's therapist listened to Karen and listened to Nina with most respectful attention to each. To understand why Nina cried, or what Nina was trying to tell us, became central to every session. To understand Karen's sadness, Karen's inarticulate cries and griefs, were equally central to the sessions. Karen was profoundly touched by her therapist's concern for her, her listening, her sympathy, her praise, and her confidence in Karen. No one had ever cared for her in this way. Later

she told the therapist how much this caring had meant to her. Karen, whose own griefs were listened to, became a mother who could listen, in every sense of the word, to her child's cries and the everyday griefs of a small girl.. She began to understand Nina's pain at separation from her each day at the door of the nursery. She had no alternatives in care for Nina but she could now find words of sympathy and understanding for Nina which made the pain bearable. In short, what Karen received in emotional sustenance from her therapist, she could now give to her own baby.

We will now pick up the story of Karen and Nina at 14 months and then later, when Nina was 26 months of age.

Once again, we want to be attentive to both the evidences of nutritional and psychological adequacy in Nina and the sustained adequacy during this period. And most important in the assessment of psychological adequacy we want to look for the qualities in human attachment that we see in Nina and in her mother.

TAPE ON. NINA AT 14 MONTHS OF AGE

NINA AT 26 MONTHS OF AGE

CONCLUDING REMARKS ON TAPE.

AT 14 months of age, Nina had reached weight adequacy and adequacy in her our psye-- affective-social evaluation. There-- we- She had also made substantial gains in cognitive motor development.

Our health evaluation showed that Nina had gained steady-- weight steadily in these 00000 7 months of work. Her weight was now 19 pounds which placed her between the tenth and 25th percentile. She was bright eyed, animated, strong, active, had good color and muscle tone. (She sustained these gains for--during-the-enti--- in later years.)

In the affective-social areas which had been seriously affee-e--- affected by the time we first met her at 7 months, Nina was now age adequate. She had a good range of affective expression. She had strong and stable ties to her mother, with strong preference for adn valuation of her mother (seeking her ^{color} for-needs-and-for-social-She-sought-her-mother-for---drnn--- seen in situations-of-- social situations as well as need states. She-showed-age-appropriate-reactions-to-the-daily-separations-from--- mother-at-the-nursery.-She-sought-and-received-comf--understanding-and-comfort-from-her-mother. She-was-mainly-a-cheerful,-busy-- Her pleasure in being with her mother was manifest through special-- semi-- warm and special smiles for her mother, animated and well-- sustained--- "conversations" with her mother, seeking her mother to share special moments and to touch base with her. She showed age appropriate reactions to the daily separations from her mother at the nursery. She protested, then settled down (with resignation) to the less than ideal circumstances-of provided by this substitute care.

There were even advances in cognitive motor development. Her-mental-development-inde-MD-I-on---MDI-on-the- At 14 months she scored an MDI on the Bayley of 133. (Her first testing had- at 7 months had actually placed her within normal range (110) But now we could see that Nina-had-- Nina's potential in mental development was higher than average. The gains reflected to some measure the great-d--strides-in-lag-tremendous progress in language development

which was one result of our work.

During this period there was ~~only~~ one developmental problem that needed our special attention. Nina would waken briefly at night wanting "to play" with her mother. We were not certain of ~~its-cause~~ the meaning of this night waking. Was this ~~patte-~~ associated with the painful separations from mother at the nursery? Was she also napping for many ~~other-~~ hours during the nursery day? We could not be sure. And the nursery had no information, no records. ~~Before--~~ While we were still trying to understand this, the night waking disappeared. We have no further information.

During this period ~~X~~ KAREN-- we saw Karen develop in to a responsible and affectionate mother. As I illustrate, it is important to keep in mind that ~~Karen's-psychological---~~ Karen was still a seriously depressed girl and was still anorexic °

~~Since~~ We had already discovered that Karen-- our treatment of Karen had to be modified because of her inability to tolerate exploration of her profound conflicts (mainly internalized rage) ~~Our-treatment-had-to--during-this-period-was-mainly-supportive-~~ (She could not tolerate even the gentlest therapeutic probing of her feelings toward her mother ~~and father~~ ~~who-continued-to-ex-~~ yet found comfort in the understanding and sympathy which ~~when~~ therapist expressed as she listened to the ~~stories-of-~~ reports of ~~maternal~~ ~~fight-be-~~ fights between the maternal grandparents, their ~~depreciation--~~ constant blame of Karen for ~~keeping-the---~~ her pregnancy bringing a baby into this home, their depreciation of Karen as mother.

delete Was Karen ^{afraid} ~~for-exam--~~ perhaps, that if we liberated the powerful feelings of rage within her that ~~they~~ might ~~encom--~~ find another target in her own baby? Nina was protected through all of her ~~and~~ Karen's defenses against anger. We would have to ~~ac-~~ accept these defenses as necessary for functioning at the present time.

Our work, then, with Karen was mainly supportive ~~and-educational---~~ ~~with-~~ and the supportive work was united with observations of Nina and developmental guidance. ~~on--~~ All of this brought significant developmental progress for Nina as we have seen. And for Karen, too, there was ~~a-moderate-lifting-of-the-de--some-~~ brightening of mood,

~~great~~ enhancement of self-image, new confidence in herself as a mother. ~~X-All-this-with-the-an--~~ The But the anorexia remained. Karen could now feed her baby, but she could not feed herself.

~~In-desac--~~

In describing the therapeutic approach to Karen, I should say- say that I am not ~~gneralizaing~~ about work with adolescents or ~~with-w-~~ work with adolescent parents. In nearly every other case we have worked with we were able to deal therapeutically with the inner conflicts of our adolesacnt parents, and to do this fairly early in ~~treament~~. Only in Karen's case was such an approach ~~not-therapeutically-indicated-for---~~ contraindicated.

Actually, we had to wait two more years before Karen's love-hate conflicts toward her parents could be dealt with therapeutically (and, I believe, with great benefit to her). But what we learn from this work is that long before the clinical picture of a mother's disorder can change, there are ^{large} ~~rich~~ possibilities for change in the capacity to mother which can be brought about through supportive treatment and guidance.

Between Nina's age 14 months and 22 months we continued to work with ~~mother~~ ^{mother} and baby. For Nina, all gains in health, affective and cognitive development were sustained.

~~In-ans-~~ At 22 months, Nina was ~~an~~ a healthy, enthusiastic, buoyant, out-going child. In ~~a-new--~~ nursery school (a new school) she was regarded by her teachers ~~and-~~ as intelligent, creative, sociaally mature for her age. She was well liked by her teachers and her peers.

In doll play in our observation sesssions we saw ~~a-te----~~ Nina as a tender and socitous mother. She loved "cooking" and "feeding" her dolls. We could not see residues of early oral conflicts.

Karen, herself, was a proud mother. Through guidance she had become a very sensitive ~~observer-of-her-child--~~ and empathic ~~obs---~~ reader of signs and needs in her child. She enjoyed Nina. She was proud of her spunkiness and assertive ness (~~av~~ a vicarious pleasure for ~~a-n-18-year-old-moth---~~ a young woman now 18 years old, who could not yet assert herself with her own parents, except in defending Nina). Some measure of ^{Karen's} self-confidence was brought ~~e-im--~~ to improved

Introduction

Developmental Conflict of Adolescence &
Mental Health

The mother - the adolescent

The father

Siblings
Treatment modalities

Self - love

depression

The Book - Describes of Adolescence

school work and a decision to enroll in a community college after high school graduation.

when NINA WAS 3 years old

It was not until the final year of treatment/that Karen's profound conflicts ~~with--of-ambiv--~~ which centered in the relationship to her own parents, could be dealt with. ~~Nina-was-then-clo--Karen--was-at-~~ In this infant--child-focused psychotherapy it was, in fact, ~~Nina-who-led-the-way--As-Karen-began-to-observe---Karen, who-could--not-even-acknowledge--annoyance---mother's-annoyance-was-her-child--was-tryi---making-unnecessary-demands, began-to-see-with-the-therapist's~~ help. At last she felt strong enough as a person to ~~spe-~~ allow herself to feel rage and disappointment toward her own parents, to speak of the heartbreaks, the childhood sense of worthlessness, the fear of parental ~~explosions~~. The depression lifted. The last vestiges of anorexia disappeared.

Karen's joy in her child had been sustained ~~ti~~ through our work. But now there was the beginning of ~~pleasure~~ joy for herself.

Karen, at last, was ready to move out of her parental home. She made good plans for herself and Nina and entered a community college technical ~~t#~~ training program. ~~Almost-at-the-same-time, the-liberation--from-parents-~~ With the liberation from parental love-hate bonds, Karen fell in love ~~for-the-first-time- &~~ with a stable young man who became devoted to her and to Nina. Within a year ~~they-were-married---~~ after termination of treatment they were married.

Discussion

Summary

A single case ~~illustration-cannot, of-course, fully---~~ of an adolescent mother and her baby cannot of course illustrate all of the factors which I have identified early in this paper as characteristics of the unresolved conflicts of ~~adolescents-w----~~ adolescence which impinge upon ~~par-~~ motherhood.

What we can see in the case of Karen and Nina are the ~~unresolved-~~ effects of profound ~~love-~~ inner conflicts in adolescence upon the capacity to mother a ~~child---~~ baby. ~~when we meet her~~ Karen/is a child, herself, caught in a morbid love-hate conflicts with her own parents. Her ~~depression~~ and anorexia speak for intense internalized rage toward her own parents.

Debbie
Main
head in
Sms?
What
do you
think

longings and ^{had}
The unsatisfied/hungers of adolescence led her to early sex experience with boys in casual encounters. She became pregnant. ^{And} she wanted to keep her baby. When we first met Nina- Karen and Nina we saw a ~~young-mother~~ starving baby-and-a-starving-mother- mother and a starving baby living in ~~the~~ ^{but} home in which ~~the-grandapr--~~ ^{Karen's} Nina's family gave grudging shelter and neither affection nor support to their child or their grandchild.. If we re- give clinical attention to Karen's own adolescent conflicts (~~putting--~~ imagining for a moment that she does not have a baby) the therapeutic task appears a formidable one. The anorexia is severe enough to warrant hospitalization. ~~The depression--~~ associated depression has depleted her- Karen's resources. She is barely able to function in school. ~~At-home~~ Failures in love have marked her life from the ~~childhood-failures--home-to-the--~~ childhood to adolescence, now marked again by the failures in seeking love from boys. There are unresolved oedipal problems in the ~~relationsh~~ pursuit of ~~love-with-~~ "forbidden love" ~~with-transient, nearly-faceless boys--sexual-encounters-with-boys-who-are-faceless-and-sometimes-nameless--~~ through transient boys, not well remembered .

But this adolescent, with some ordinary and many extraordinary developmental problems is a mother. ~~her-~~ And her baby is ~~endangered-~~ in great danger.

Anorexia has distorted Karen's ability to read her own signs of hunger and satiation. Anorexia has ~~a~~ blotted out her recognition of hunger and satiation in her infant. Depression, which makes her psychologically "absent" in all social relationships, has ~~made~~ her psychologically absent to a baby who is most imperatively in need of ~~nurture-and-~~ mother nurture. ~~The-self-absorption-~~

The baby, herself, seems not quite real to Karen when we ~~ma-~~ first meet her. She is uncertainly a mother. ~~There is an--~~ She still needs a mother herself. Her own longings for nurture collide at times with the baby's needs for nurture. And the fantasy baby who would satisfy ~~uncertain-i--~~ longings to be loved, and the yearning for self-renewal which are universal in adolescence, is after all only a baby with imperative demands, and a no promise of bringing self-renewal. The baby-~~who-~~ of fantasy who would "fill the emptiness" ~~does-not-~~ only enlarges the sense of emptiness. At best, if Karen summons all of her meager resources, she can give mechanical care to ^{her} ~~hina~~ .

And Karen has no model~~s~~ for mothering. Her own mother's failure to mother leaves Karen bereft of knowledge and tradition.

~~But Nina, the baby is~~

We can ~~easily~~ sketch the treatment for Karen if Karen were not a mother. Many months of intensive work would be required. Hospitalization of Karen might be desirable [^]

But Nina, the baby, is our patient, too. She cannot wait for her mother's depression to lift, ~~for the anorexia-~~ or ^{bound together} the ~~anorexia-~~ resolution of the complex problems that are ~~embraced-~~ in anorexia. ~~Under-optimal-circumstances--~~

Our work with Karen and Nina focused on the needs of both the baby and the mother. It was a delicate balance to sustain, for ~~ofte-~~ Karen, like many adolescent mothers we know, was ~~so-~~ desperately needy herself. The largest number of sessions were held with both mother ~~and~~ baby in the room. When necessary private sessions for Karen, herself, were arranged.

Psychotherapy is a form of undoing of the past. And so it was for ~~Karen~~, too, even though our access to the emotionally laden memories of the past was limited by Karen's own defenses against powerful ~~emotion~~ ^{affects}. Where rejection by parents had led to Karen's ~~feelings of worthlessness, we-~~ therapy-could-give-back-- the relationship to the therapist could give to Karen a sense of worth as an adolescent, and as a mother. Where ~~longings-for-mother-love-~~ unsatisfied longings for mother-love had led to morbid symptoms, therapy could provide a form of psychological nurturance which sustained the adolescent girl and ~~gave-her--~~ had the effect, I think, of undoing some part of the injuries of the past. Where ~~und-~~ failures in understanding had ~~broken-~~ marked the relationship with parents, understanding and profound sympathy from a therapist, had the effect of ~~undoing-~~ healing the old wrongs. Where the baby was somehow ~~a~~ "a child of sin" with echoes ^{from} to an unremembered past, ~~the-~~ baby-was-given- and censorship from the ~~maternal~~ parents, the baby was given ~~new--~~ through our work, the ~~real~~ rights of every baby to be cherished and to bear no ~~ancient-si-~~ shameful stigma, ^{the} Where the baby was uncertainly a fantasy baby, who belonged to an oedipal romance, ~~we-made-the-baby-~~ we helped to make the baby a real baby, a real person, which had the effect of detaching the baby from ~~old--~~ childhood conflicts even ~~though~~ we were unable to deal directly with those

Debbie
Newark

fantasies directly. And long before we were able to deal with the inner conflicts of Karen in our treatment, Nina, herself, began to fulfill her mother's ~~dream-of renewal, through--of-re-birth-through~~ adolescent dream of renewal of self, ~~through-~~ a re-birth through the giving birth to a child. Nina, through our work, became ~~a-joyful--~~ ^{a loving} ~~an-affectionate,~~ even- intelligent, social little person who gave her mother huge rewards for motherhood. The mother who could not love herself or value herself when we first met her could know love and valuation from her child. Some measure of self-love could now grow in Karen, which means of course, that for Karen, as well as all parents, a ~~rewarding-~~ loving and rewarding child brings- brought enhancement of self-love, the ~~healthy-narcissism-that--~~ healthy narcissism that is the ~~right-~~ privilege of all parents.

Nina's ~~de-~~ progress in treatment was ~~more-~~ far in advance of her mother's during the first two years. Nina was brought to adequacy on all measures of personality development ~~long-before--~~ by the time she was 14 months old. ~~The-work-~~ But in this work we have two patients, ~~-As-long-as--~~ a mother and a ~~ch~~ baby. As long as Karen's depression remained Nina was regarded by us as at risk. ~~The--~~ ~~work--~~ and her mother's psychological ~~status-~~ state was regarded as precarious. When treatment was terminated at Nina's age 3 1/2 we were satisfied that Karen's internal conflicts had found resolutions and that Nina was sturdily progressing in her own development.

~~A child-focused psychotherapy for the adolescent parent gives us, I believe, the--~~

Therapeutic work with adolescent mothers and their babies needs to accommodate ~~the~~ objectives ~~of~~ for the treatment of two patients, each ~~with-~~ of whom may be suffering from a developmental disorder. ~~The-ther~~ This therapy has the aim of ~~providing--~~ bringing optimal development for an adolescent who is also an adolescent mother and for a baby whose development is ~~either-manifestly-or~~ endangered.



Managing Editors

SHERMAN C. FEINSTEIN, M.D.
741 ST. JOHNS
HIGHLAND PARK, ILL. 60035
PETER L. GIOVACCHINI, M.D.
278 LOCUST ROAD
WINNETKA, ILL. 60093

ADOLESCENT PSYCHIATRY

Advice to Authors

↓ 10

The Annals of the American Society for Adolescent Psychiatry is published by the University of Chicago Press. Because the volume is distributed in an international market, every effort should be made to use a "simple, straightforward idiom" eliminating technical jargon and slang. Cross-references should be made to chapters or sections; avoid using "above" or "below" as references. Generally, Adolescent Psychiatry is edited according to the University of Chicago Manual of Style (12th ed., rev.).

- I. General instructions. Manuscripts must be typed double spaced (text, notes, references, legends, etc.), on 8-1/2 x 11-inch paper. Allow right- and left-hand margins of at least 1-1/2 inches each.
- II. First page of manuscript.
 - A. Title should be at least 2 inches from top edge of paper.
 - B. Allow 1-inch space, and on a separate line type the name(s) of the author(s).
- III. Subheads should be used sparingly, with the major headings describing the contents of all minor headings under them. Headings should be a label, not in sentence form, typed on a separate line in capitals and lower case.
- IV. Notes, used sparingly, should be typed paragraph style on a separate sheet of paper following the text. If there is an acknowledgment note, it should be unnumbered and should precede the numbered Notes, which should be numbered consecutively and correspond with the numbers cited in text. Notes are only necessary for further explanation of something within the text. They are not necessary if only to refer to a work cited.
- V. References should be compiled on a separate sheet, following Notes, in alphabetical order by authors' names. Where several items by the same author is included, they should be listed in chronological order. For separate References to different works by the same author in the same year, alphabetize by article title with (a) after the year given for the first Reference, (b) after the second, etc. In text, they should be designated the same way.

In text, References should include the author and the year of the original publication in parentheses. Example:

... by what Freud (1925) indicates.

... of aesthetics (Kohut 1972a) has put ...

Examples of References:

Freud, S. 1925. Negation. Standard Edition 19:233-39. London: Hogarth, 1961.

Keniston, K. 1971. Youth as a stage of life. Adolescent Psychiatry 1:161-175.

Kohut, H. 1972a. Thoughts on narcissism and narcissistic rage. Psychoanalytic Study of the Child 27:360-400.

Kohut, H. 1972b. Adolescent process as a transformation of the self: discussion of E. S. Wolf, J. E. Gedo, and D. M. Terman. Paper presented before the Chicago Psychoanalytic Society, May 23, 1972.

Stokes, A. 1955. Form in art. In M. Klein, P. Heiman, and M. Money-Kryle, eds. New Directions in Psychoanalysis. New York: Basic.

Winnicott, D. W. 1957. Mother and Child. New York: Basic.

- VI. Tabular material. Each table should be on a separate sheet of paper following the References. Each table should be numbered and should be referred to in order in the text.
- VII. Submission of manuscripts. Send the original and three copies to: Annals of the American Society for Adolescent Psychiatry, c/o Sherman C. Feinstein, M.D., 741 St. Johns, Highland Park, Illinois 60035. Include author's academic degrees, highest academic title, and a short list of important appointments.

THE ADOLESCENT MOTHER AND HER INFANT

Selma Fraiberg

In this paper I will describe our work with adolescent mothers and their infants in an infant psychiatry program. In the first part of this paper I have gathered together some of our clinical observations of a group of young mothers struggling with formidable developmental conflicts of adolescence and their new and uncertain identity as mother to an infant. In the second part of the presentation, I will describe our treatment of one 16-year-old, severely depressed mother and her failure to thrive infant.

As the basis for this presentation I have chosen a group of ten babies and their eight adolescent mothers who constituted a subgroup in our intensive treatment caseload in our University of Michigan program during the period November, 1972 to October, 1978. The ten babies represented 20% of our intensive treatment caseload of fifty. Since the only criteria for entering our intensive treatment program were our assessment of need for this form of treatment and the practical limitations of a small staff, it is important to note that teenage mothers constituted a substantial number of those we had identified as severely impaired

in critical areas of functioning.

Characteristics of the Group:

The ages of the mothers at the time of delivery ranged from sixteen to eighteen. Five were unmarried girls. Of the three mothers who were married, one was separated from her husband. The five fathers in the never-married group are unknown to us, and in fact, broke connections with the girl soon after pregnancy was confirmed. They appear in our records as nameless and faceless, and in each case were partners in casual encounters.

Seven of the ten babies were firstborn. All of the babies were full term with birth weights within the normal range. Congenital defects were later identified in three of the children. All of the mothers were living in poverty. The five unmarried mothers were supported by AFDC. In nearly all cases the young mother was living apart from her family of origin, and encounters with the extended family were caught up in conflict and turmoil. There were neither psychological support for mother and baby nor traditions of childrearing to guide a young girl who was unready for motherhood.

The five unmarried mothers were attending school or were enrolled in job training. Their babies were being cared for in day-care centers or family day-care. Mainly, the day-care arrangements, which we ourselves could assess through visiting, were poor, and offered little more than custodial care. In three

cases there was outright neglect of infants. As we came to know the babies and their families, we were sobered by the fact that the child, endangered by the considerable pathology in the mother, and already showing signs of a severe attachment disorder, was further endangered by the circumstances in which he received indifferent or neglectful substitute mother care. The baby who needed an optimal day-care program was receiving substitute care of the poorest quality.

The babies and their mothers had been referred to us by physicians, nurses and social workers in Wasthenaw County (population approximately 300,000). The babies of teenage mothers were, as a group, among the most severely impaired children in our caseload. A primary attachment disorder was present at the time of referral in each case. Four of the babies had been hospitalized for failure to thrive. The teenage mothers, as a group, showed grave impairment in psychological functioning and were virtually incapacitated in mothering a baby. Although they had been labeled by their community as "neglectful" and "rejecting", none of them had been evaluated by a psychiatric team until they came into our program. Ideally, we would like to see a psychosocial assessment of the teenage mother in every case, at the point where the pregnant girl is first identified by the health provider. After our own diagnostic study, six of the eight mothers were seen by us as severely depressed. Depression in each of these cases

had been present for many months and even years before the baby was conceived. In fact, as I shall later discuss, depression and the unsatisfied psychological hungers which were entwined with depression, had found their way into longing for a baby.

Developmental Conflicts of Adolescence and Motherhood

When I speak, now, of the interlocking development conflicts of adolescence and motherhood which we saw in this group of young girls, I should preface these remarks with some caution. Clearly, the group of severely disordered teenage mothers in our caseload do not represent the larger population of teenage mothers, in which we can find a fair amount of adequate or excellent mothering. And when I describe the adolescent conflicts and mothering conflicts which we encountered, they are not typical, I feel, but are exaggerated and heightened conflicts, in which universal problems of adolescent maturation ^{have} become distorted by disorder in the adolescent personality and the inability of the primary family of the girl to provide the vital pathways to resolution of conflict. The girl and her family, in our cases, were locked together in a morbid conflict.

The diagnostic study and treatment of this group of young mothers and their infants brought into focus the interlocking conflicts of adolescent development and mother-infant relationships. Each of these mothers had become pregnant at a point in psychological development when attachment and detachment from the primary family figures had produced conflicts of considerable magnitude.

The unresolved conflicts of adolescence became the focus of new conflicts which embraced the child. The attachment and detachment problems of the mother were mirrored in the disorders of attachment which we saw in the baby.

The baby was caught up in the morbid past and uncertain present of his mother, but he was also most poignantly the symbol of hope and self-renewal in his mother. Each of the unmarried girls, it should be noted, had examined the alternatives of abortion and adoption, and had chosen to keep the baby. They wanted their babies and kept them against the wishes of their own parents. In each case, the baby, when we met him, was manifestly neglected and showed impoverishment in all areas of human attachment. The contradiction between the adolescent mother's daydreams for the baby and the actual state of the baby needed to be understood.

As we came to know these adolescent mothers, we saw how many of the typical conflicts of adolescence had become intensified and magnified for each of these girls before they became pregnant. Their own mothers were at the center of these conflicts, and by the time we came to know them, these conflicts appeared to consume the life energies of each. In normal adolescence we may see the love-hate conflicts of the girl surface in daily life, but after the storm the beloved aspects of the mother can be reclaimed. What is preserved and eventually consolidated in the course of adolescence becomes available for positive identification and

integration of personality in late adolescence. But among the young girls in our group, the mother as enemy and betrayer dominated the theater of conflict, and there appeared to be no aspect of this mother that could serve maturation and identification. It also seemed to us that the mothers of these girls had become the unwitting collaborators in this tense family drama, transforming themselves into the enemy, so that the fantasy mother and the real mother sometimes merged.

Side by side with these consuming struggles with the mother was dependency in the girl and a longing for nurturance from the mother, which was explicitly brought to us in their stories and re-enacted in transference with the therapist. Often, when the therapist was visiting the young mother and her baby in the home, there were two crying children in that living room.

The unresolved mother conflicts of the girl became impediments to mothering and to the attachment of the girl to her baby. A girl who is fighting against her tie to her mother, who sees her mother as an enemy without redeeming features, has nothing good or solid to hold onto when she seeks a model for herself as a mother. And a girl who is still longing for a mother, who wants a mother to hold her close, nourish her, is not ready to become a mother herself.

Much of the important work that we accomplished in our treatment of these teenage mothers grew out of our exploration of the

mother conflicts which were paralyzing the girl in her own psychological development. We examined the love-hate relationship to the mother, as they were described to us and as they were re-enacted in transference to the therapist. We provided, through our treatment, a form of psychological nurturance for hungry girls. We offered a relationship in which independence could grow out of dependency, and affection and trust for the therapist could provide the conditions for new identifications with an adult figure and alternative models for mothering. The listening and understanding which the therapist gave the young mother could be transformed into listening to and understanding of a baby. Again and again, in our records, the therapist is in a room with a crying mother and a neglected and crying baby, and the therapist offers words of comfort to the mother and the mother turns to the crying baby as if she has heard him for the first time.

The adolescent girl's father, as he was described to us and revealed through the eyes of the girl, was also at the center of love-hate conflicts. We expect that in the normal adolescent process the girl's attachment to her father is gradually modified, that the oedipal wishes and fantasies are transformed and that resolution paves the way to the discovery of new partners in love. Among the adolescent mothers in our group, the childhood daydream of father-love had been preserved and was re-enacted with male partners who appeared as transient lovers - if, indeed, the word

"lovers" should be used.

Since the attachment to the father was still primary, there was no possibility of forming an enduring bond with another male partner. Typically among our girls, sexual activity had begun at the age of 13 or 14. The sexual partners were distantly remembered and seemed to have no more substantiality than figures in a fantasy. And, in fact, the sexual experiences resembled fantasies in which each partner was interchangeable with the other, like the masturbation fantasies of early adolescence. What was acted out in these transient sexual episodes was the fantasy of forbidden and dangerous love, a transparent oedipal fantasy. When pregnancy occurred, the unconscious childhood fantasy of having a baby with the father added another psychological dimension to a crisis, and the baby, when he arrived, became the embodiment of a shameful secret, a "child of sin", in the old-fashioned phrase.

The baby was also the child of a profound disappointment, the result of a promise that was not kept by whoever it is in our society who makes promises to the young. In the hyped-up sexual climate of our times, it is easy for the young to believe that puberty carries a passport into sexual bliss. But not one of the young girls in our group had experienced sexual pleasure of any kind in their many encounters. In fact, the serial encounters were motivated by the search for sexual joy. "It'll be different with the next fellow." But it never was. These girls were, in

fact, unready for sexual fulfillment, like the majority of adolescents in their early and mid-teens. But clearly, for the girl we are speaking of, a girl who is still pursuing a childhood fantasy love with her father, there is no place yet for a new partner and uninhibited sexual joy. The father-love becomes the inhibitor.

The father-love also becomes an impediment to motherhood. A girl who is still playing out an unconscious childhood fantasy of make-believe love and make-believe union with her father is likely to continue this fantasy as a make-believe mother with a make-believe baby. And this, in fact, is what we saw when we first met the mothers and babies in our group. Motherhood was somehow unreal. The baby was not quite real.

In our infant-focused psychotherapy we listened to the tangled stories of fathers and lovers, and helped the adolescent mother to find new solutions to old griefs and old longings. As we watched the mother and her baby together in session after session, we were attentive to those aspects of the baby and of mothering which were caught up in the old daydream. Where the baby was somehow unreal, and motherhood was unreal, we could make them real. This was not a fantasy baby to us; he was a person with all the unique qualities of his own personality. She was not a pretend mother, to us; she was a real mother with real concerns for her baby and real problems. We played with this real baby and revealed his marvelous attributes to his mother. We

talked to the real mother and most respectfully gave her the authority and prestige of mother. She was not a child to us, innocent and blundering, but a mother trying very hard to be a mother in the midst of terrible hardship.

The unresolved conflicts of childhood embraced every aspect of the childhood family. Repeatedly, in our work with adolescent mothers, we saw intense sibling conflicts re-enacted with the baby. Jealousy toward the baby, competition with the baby, anger toward the baby, the feeling of being robbed of something precious by the baby, were recurring themes which we could trace back in treatment to a sibling who had been a rival in childhood. Normally, in adolescence, the sibling conflicts of childhood undergo resolution along with other early and intense love-hate relationships of the family. When the adolescent process has not been completed through maturation, the old jealousies and hostilities stand ready for transference to other objects. Tragically, in the case of teenage motherhood, the new baby may come to represent the old rivals in the family of childhood.

In our work with the adolescent mother, we examined those ways in which the baby was caught up in old memories and the conflicts of the childhood family of the mother. We helped the mother to disentangle her baby from the figures of childhood and free the baby from the ghosts in the maternal past.

The inventory of unresolved adolescent conflicts in motherhood

should include conflicts between self-love and love of others.

Adolescence is normally a time in which self-love appears in heightened forms. The egocentricity and narcissism of the adolescent are, under all normal circumstances, only headaches that parents and teachers need to live with for a while. But when the adolescent becomes a parent, the self-love and self-centered goals come into conflict with the needs of a baby and the requirements of parenthood. A mother needs to put the child's needs before her own needs, and is able to do this when psychological maturation has given her the possibility of subjugating self-interest and self-love in the interest of a child. The adolescent girl who has not completed this maturational step finds herself strained, or actually incapable, at times, of ministering to the ordinary needs of a helpless baby.

It is this colossal narcissism in the young that evokes anger in the parent generation. When the adolescent is also a mother, the self-centeredness of the mother, united with neglect of her infant, evokes anger in those who are called upon to help her. By the time we met our young mothers, they had been scolded by public health nurses, doctors, and social workers, and grimly prepared themselves for a scolding from us. They seemed surprised, but certainly relieved, when no scolding awaited them.

Narcissism in parenthood, it strikes us, has two faces. There is the self-love that can endanger the child, and there is the self-love that can embrace the child. There is a large measure of

healthy narcissism that goes into the parenting of many good and normal people. The baby is the most remarkable baby in the world. He's a genius, if we have to say it ourselves. Every achievement, even his first tooth, is somehow a credit to us, as parents. All this, the healthy narcissism, is available to the teenage parent, too. We began to see it happen in our work. As the baby began to thrive and reward his mother for her efforts, he became, for his young mother, a marvel, a precocious child, destined for a brilliant future.

From this brief summary, we can see how the intense unresolved conflicts of adolescence become psychological obstacles to the nurturance of a child and may, in fact, provide a theater in which the baby is caught up in the re-evoked childhood griefs and disappointments of the mother. In our group, however, there was still another dimension of conflict which exerted its morbid influence upon the baby, and this was maternal depression.

Six of the eight adolescent mothers were suffering with severe and incapacitating depression. If these girls had not been mothers, they would have required intensive psychotherapy and, in two cases, might have required hospitalization for depression related anorexia. While these young mothers had been labeled by their communities as "rejecting", neglectful, or abusive toward their children, our clinical inquiry led us to understand that these were young girls who were barely able to function. In each case, the depression

had antedated pregnancy and the birth of the child by many months and even years. Since each of these girls had considered the alternatives of abortion and adoption, the decision of these depressed young girls to keep their babies needed to be understood. What did the baby represent? In the course of our work we began to understand. In the hopelessness of depression, the baby represented "hope" and "renewal", the chance to live another life through the baby of fantasy. The hunger for love in the adolescent and the unsatisfied hungers seen in depression found the dream of a baby's love. And not only love, we saw, as we began to unravel the complex meanings of the baby. Periodically, in the course of treatment, the depressed young girl would speak of feelings of emptiness and a yearning for something to fill the emptiness. And, as we moved back into the historical events that had led to pregnancy and the decision to keep the baby, we began to understand. The yearnings for a baby seemed linked to an imperative need "to fill the emptiness."

The baby, being a baby, could not fill the emptiness for needy and hungry girl-mothers. The baby, in fact, was a disappointment. Neither did the baby bring self-renewal or the fulfillment of old dreams. More likely, the bad dreams of childhood were re-evoked by him. The baby had become the center of morbid conflicts by the time we met him.

The Babies: Disorders of Attachment

It's time to talk about the babies. In each of these cases the baby had come to us because of severe disorders of attachment. Here, I am not generalizing to the larger population of infants of teenage mothers. We must remember that, as a psychiatric clinic, we were preselected by referring agencies for our expertise in the area of attachment disorders. The babies, as a group, were among the most severely impaired children in our caseload. They were joyless, listless babies, who showed virtually none of the age-appropriate signs of attachment to their mothers, or who had a limited repertoire of attachment behaviors along with a constricted range of affect. Four of the ten babies were referred to us following diagnosis of failure to thrive.

As we follow the links between the adolescent conflicts of the mothers in our group and the disorders of attachment we identified in their babies, we can see how every component of the unresolved adolescent conflicts became an impediment to the attachment of mother to baby and baby to mother. Where resolution of childhood conflicts paves the way for parenthood and identification with one's own parents, nonresolution brings unreadiness, disappointment, and a turning away from the baby or the investment of the baby with the love-hate conflicts of the mother's own childhood. Where self-love is still dominant in adolescent psychology, there cannot be the selfless love of a parent. And when we add to

this inventory of adolescent afflictions the severe depressions we encountered among the mothers in our group, it appears as if everything in the parental personality is negating the possibility of attachment.

Yet this is by no means a hopeless picture for therapy. Remarkably, when we consider the psychopathology we saw in mothers and babies, we found that we were able to engage each of these mothers in work on behalf of their babies and themselves, and the therapeutic gains were substantial in all but one case.

Clinical Illustration

The case of 16-year-old Karen and her baby, Nina, illustrates many of the interlocking disturbances of mother and baby.¹ It also illustrates our methods of diagnostic study and the formulation of treatment alternatives which grow out of the initial assessment.

No case can stand by itself in illustrating the clinical picture that we saw in our caseload of teenage mothers and their babies. However, the case of Karen and Nina illustrates many of the characteristics of our larger group. Nina, the seven-month-old baby, is referred to us following hospital diagnosis of "non-organic failure to thrive due to maternal deprivation".

At birth, Nina had been a full term healthy baby, birth weight six pounds one ounce (10th percentile) and height was twenty inches (75th percentile). At the time of hospitalization for failure to thrive, Nina's weight had dropped to below the third percentile and

height had fallen to below the 25th percentile. Medical study revealed no organic cause for failure to thrive and the referring pediatrician and nurses concluded that growth failure was caused by severe maternal deprivation.

Her sixteen-year-old mother is unmarried and attending high school. The mother is described as neglectful and unable to cooperate with physicians and nurses who have offered their help. When we meet the mother and baby, we see a young mother who is suffering with a severe depression and a depression-related anorexia which has antedated the birth of the baby by several years. Karen, the mother, weighs approximately eighty-five pounds. Food is repulsive to her, she tells us, and she eats barely enough for sustenance. She knows the doctors are concerned about Nina, but she is not sure why. Nina looks chubby to her, she says.

Karen and Nina are supported by AFDC. They are living in the home of the maternal grandparents in the midst of domestic chaos. There are violent quarrels between Karen's mother and father, periodic separations. Karen and Nina are given grudging shelter in this home. Nina is unwanted. Karen is taunted daily by her parents for bringing a baby into this home. No help is offered Karen. Karen would like to find another place to live. But she is afraid to live alone. What is she afraid of? "Of noises. Animals. Burglars." She is a child herself, of course. The grandparents themselves are hostile to the treatment offered

Karen and Nina. They will not permit us to visit the home. If Karen wants our help she will have to see us at our office. With all these constraints we will need to provide treatment for this endangered baby and her mother.

In the course of the initial evaluation period, we are asking ourselves many questions. The developmental testing of Nina will give us a fair assessment of the motor and cognitive development of Nina and the areas of deficit, if they exist. But the test will not help us to discern the qualities of infant-mother relationship. In our observations, we want to look for the age-appropriate indicators of human attachment in the baby, and the ability of the mother to respond to the range of signs and signals which a baby can send to the mother, and the ability of the mother to initiate and exchange social and affectionate signs with her baby.

In our initial observations we see a severely depressed young mother and her child who is suffering from growth failure and a severe attachment disorder. The depression of the mother is mirrored in the baby's face. The baby is silent, stares off into space, uninvested in her surroundings. She rarely turns to her mother for a social exchange or for comfort. In our broader observations, we see a limited number of attachment indicators. There is discrimination of her mother from others, there is preference for her mother. Nina has a limited repertoire of attachment behaviors, but they are muted and joyless. Similarly, Karen shows some signs

of affection for her baby, but she sinks back into depression and solitude after each exertion.

As we look at the depressed and anorectic mother, we also look at our own therapeutic dilemma. Karen cannot read the signs of hunger and satiation in herself; how can she read the signs of hunger and satiation in her baby? In fact, in every observation during this assessment period of seven sessions, Karen seems unable to read hunger in Nina, or misreads the signs.

Ideally, we would want our therapy to focus on the interlocking aspects of Karen's depression and her baby's attachment disorder. But soon after treatment begins, we find ourselves facing a formidable therapeutic problem. If the therapist begins to speak about feelings with Karen, to speak of sadness or anger, to touch ever so gently upon the defenses against affect, Karen's depression deepens and her symptoms are exacerbated.

Clearly, we cannot yet deal with Karen's internal and objective conflicts without precipitating a grave conflict in personality, and worsening the situation for Karen and Nina. We decide, then, that we will work with Karen and Nina, for the indefinite future, within the context of supportive treatment and developmental guidance. This treatment brings about very substantial changes for Karen and Nina.

Our treatment focused on both the nutritional and psychological aspects of Nina's and Karen's interlocking conflicts.

But both aspects of this treatment were solidly embedded in the context of human attachments. On the nutritional side, we worked with Karen and the nursery in providing an optimal diet for Nina. Karen and the nursery staff were helped to see how a baby's pleasure in eating was intimately related to pleasure in the arms of a partner, most particularly the mother. Karen was encouraged to take over the lunch feedings in the nursery as often as possible. One (or at most, two) aides at the nursery was assigned as Nina's special caregiver.

In our own sessions with Karen and Nina and the therapist together in our playroom, the therapist focused on the relationship between Nina and Karen, emphasizing in every way possible how Karen was the most important person in the world to her baby, how no one, not the therapist either, could get the special smiles from Nina, and no one could comfort Nina in distress as well as her mother could. Karen, who had never in her life believed she was important or special to anyone, was deeply touched as she learned to recognize these signs of preference and love in her baby. And Nina, like all babies, gave generous rewards to her mother. Within four months of work, Nina made tremendous progress toward nutritional adequacy and psychological adequacy.

Karen, watching the therapist talk to Nina, was initially puzzled. After all, Nina could not understand English. Karen had no traditions in her family for talking to a baby, or indeed, for

conferring personality upon a baby. As Karen watched her therapist, she saw that Nina began to make responsive sounds, and it was easy for the therapist to begin to speak about how babies learn to talk. Within a short time, mother-baby dialogues appeared in all of our sessions, and the quiet baby who never uttered a sound became positively gregarious.

Karen's conflicts with her own parents gave her no models for parenting. Her own mother did not like babies and considered a baby who cried as "just plain spoiled". Her own mother did not believe that a baby of Nina's age cared who took care of her. Mothers were not important. Karen's therapist listened to Karen and listened to Nina with most respectful attention to each. To understand why Nina cried, or what Nina was trying to tell us, became central to every session. To understand Karen's sadness, Karen's inarticulate cries and griefs, were equally central to the sessions. Karen was profoundly touched by her therapist's concern for her, her listening, her sympathy, her praise, and her confidence in Karen. No one had ever cared for her in this way. Later she told the therapist how much this caring had meant to her. Karen, whose own griefs were listened to, became a mother who could listen, in every sense of the word, to her child's cries and the everyday griefs of a small girl. She began to understand Nina's pain at separation from her each day at the door of the nursery. She had no alternatives in care for Nina but she could

now find words of sympathy and understanding for Nina which made the pain bearable. In short, what Karen received in emotional sustenance from her therapist, she could now give to her own baby.

At fourteen months of age, Nina had reached weight adequacy and adequacy in our affective-social evaluation. She had also made substantial gains in cognitive motor development.

Our health evaluation showed that Nina had gained weight steadily in these seven months of work. Her weight was now nineteen pounds which placed her between the tenth and twenty-fifth percentile. She was bright eyed, animated, strong, active, had good color and muscle tone. (She sustained these gains in later years.)

In the affective-social areas which had been seriously affected by the time we first met her at seven months, Nina was now age adequate. She had a good range of affective expression. She had strong and stable ties to her mother, with strong preference for and valuation of her mother (as we saw in social situations as well as need states). Her pleasure in being with her mother was manifest through warm and special smiles for her mother, animated "conversations" with her mother, seeking her mother to share ^{special} moments and to touch base with her. She showed age appropriate reactions to the daily separations from her mother at the nursery. She protested, then settled down (with resignation) to the less than ideal circumstances provided by this substitute

care.

There were advances in cognitive motor development. At fourteen months she scored an MDI on the Bayley of 133. Her first testing at seven months had actually placed her within normal range (110), but now we could see that Nin's potential in mental development was higher than average. The gains reflected to some measure the tremendous progress in language development which was one result of our work.

During this period there was one developmental problem that needed our special attention. Nina would waken briefly at night wanting "to play" with her mother. We were not certain of the meaning of this night waking. Was this associated with the painful separations from mother at the nursery? Was she also napping for many hours during the nursery day? We could not be sure. And the nursery had no information, no records. While we were still trying to understand this, the night waking disappeared. We have no further information.

During this period we saw Karen develop into a responsible and affectionate mother. As I illustrate, it is important to keep in mind that Karen was still a seriously depressed girl and was still anorectic.

We had already discovered that our treatment of Karen had to be modified because of her inability to tolerate exploration of her profound conflicts (mainly internalized rage). She could

not tolerate even the gentlest therapeutic probing of her feelings toward her mother and father, yet found comfort in the understanding and sympathy which the therapist expressed as she listened to the reports of fights between the maternal grandparents, their constant blame of Karen for bringing a baby into this home, their depreciation of Karen as mother.

Our work, then, with Karen was mainly supportive and the supportive work was united with observations of Nina and developmental guidance. All of this brought significant developmental progress for Nina as we have seen. And for Karen, too, there was brightening of mood, enhancement of self-image, new confidence in herself as a mother. But the anorexia remained. Karen could now feed her baby, but she could not feed herself.

In describing the therapeutic approach to Karen, I should say that I am not generalizing about work with adolescents or work with adolescent parents. In nearly every other case we have worked with we were able to deal therapeutically with the inner conflicts of our adolescent parents, and to do this fairly early in treatment. Only in Karen's case was such an approach contraindicated.

Actually, we had to wait two more years before Karen's love-hate conflicts toward her parents could be dealt with therapeutically (and, I believe, with great benefit to her). But what we learn from this work is that long before the clinical picture

of a mother's disorder can change, there are large possibilities for change in the capacity to mother which can be brought about through supportive treatment and guidance.

Between Nina's age fourteen months and twenty-two months, we continued to work with mother and baby. For Nina, all gains in health, affective and cognitive development were sustained.

At twenty-two months, Nina was a healthy, enthusiastic, buoyant, outgoing child. In nursery school (a new school) she was regarded by her teachers as intelligent, creative, socially mature for her age. She was well liked by her teachers and her peers.

In doll play in our observation sessions we saw Nina as a tender and solicitous mother. She loved "feeding" and "cooking" for her dolls. We could not see residues of early oral conflicts.

Karen, herself, was a proud mother. Through guidance she had become a very sensitive and empathic reader of signs and needs in her child. She enjoyed Nina. She was proud of her spunkiness and assertiveness (a vicarious pleasure for a young woman now eighteen years old, who could not yet assert herself with her own parents, except in defending Nina). Some measure of Karen's self-confidence was brought to improved school work and a decision to enroll in a community college after high school graduation.

It was not until the final year of treatment when Nina was

three years old that Karen's profound conflicts which centered in the relationship to her own parents, could be dealt with. At last she felt strong enough as a person to allow herself to feel rage and disappointment toward her own parents, to speak of the heartbreaks, the childhood sense of worthlessness, the fear of parental explosions. The depression lifted. The last vestiges of anorexia disappeared.

Karen's joy in her child had been sustained through our work. But now there was the beginning of pleasure for herself.

Karen, at last, was ready to move out of her parental home. She made good plans for herself and Nina and entered a community college technical training program. With the liberation from parental love-hate bonds, Karen fell in love with a stable young man who became devoted to her and to Nina. Within a year after termination of treatment they were married.

Discussion

A single case of an adolescent mother and her baby cannot, of course, illustrate all of the factors which I have identified early in this paper as characteristics of the unresolved conflicts of adolescence which impinge upon motherhood.

What we can see in the case of Karen and Nina are the effects of profound inner conflicts in adolescence upon the capacity to mother a baby. Karen, when we meet her, is a child, herself, caught in a morbid love-hate conflict with her own parents. Her

depression and anorexia speak for intense internalized rage toward her own parents. The unsatisfied longings and hungers of adolescence had led her to early sexual experience with boys in casual encounters. She became pregnant. And she wanted to keep her baby. When we first met Karen and Nina we saw a starving mother and a starving baby living in the home in which Karen's family gave grudging shelter and neither affection nor support to their child or their grandchild. If we give clinical attention to Karen's own adolescent conflicts (imagining for a moment that she does not have a baby) the therapeutic task appears a formidable one. The anorexia is severe enough to warrant hospitalization. Depression has depleted Karen's resources. She is barely able to function in school. Failures in love have marked her life from childhood to adolescence, now marked again by the failures in seeking love from boys. There are unresolved oedipal problems in the pursuit of "forbidden love" through transient boys.

But this adolescent, with some ordinary and many extraordinary developmental problems, is a mother. And her baby is in great danger.

Anorexia has distorted Karen's ability to read her own signs of hunger and satiation. Anorexia has blotted out her recognition of hunger and satiation in her infant. Depression, which makes her psychologically "absent" in all social relationships, has made

her psychologically absent to a baby who is most imperatively in need of mother nurture.

The baby, herself, seems not quite real to Karen when we first meet her. She is uncertainly a mother. She still needs a mother herself. Her own longings for nurture collide at times with the baby's needs for nurture. And the fantasy baby who would satisfy longings to be loved, and the yearning for self-renewal which are universal in adolescence, is after all only a baby with imperative demands, and no promise of bringing self-renewal. The baby of fantasy who would "fill the emptiness" only enlarges the sense of emptiness. At best, if Karen summons all of her meager resources, she can give mechanical care to Nina.

And Karen has no models for mothering. Her own mother's failure to mother leaves Karen bereft of knowledge and tradition.

We can sketch the treatment for Karen if Karen were not a mother. Many months of intensive work would be required. Hospitalization of Karen might be desirable. But Nina, the baby is our patient, too. She cannot wait for her mother's depression to lift, or for resolution of the complex problems that are bound together in anorexia.

Our work with Karen and Nina focused on the needs of both the baby and the mother. It was a delicate balance to sustain, for Karen, like many adolescent mothers we know, was desperately needy herself. The largest number of sessions were held with both mother

and baby in the room. When necessary, private sessions for Karen, herself, were arranged.

Psychotherapy is a form of undoing of the past. And so it was for Karen, too, even though our access to the emotionally laden memories of the past was limited by Karen's own defenses against powerful affects. Where rejection by parents had led to Karen's feelings of worthlessness, the relationship to the therapist could give to Karen a sense of worth as an adolescent, and as a mother. Where unsatisfied longings for mother-love had led to morbid symptoms, therapy could provide a form of psychological nurturance which sustained the adolescent girl and had the effect, I think, of undoing some part of the injuries of the past. Where failures in understanding had marked the relationship with parents, understanding and profound sympathy from a therapist had the effect of healing the old wounds. Where the baby was somehow "a child of sin" with echoes from an unremembered past, and censorship from the maternal parents, the baby was given, through our work, the rights of every baby to be cherished and to bear no shameful stigma.

Where the baby was uncertainly a fantasy baby, who belonged to an oedipal romance, we helped to make the baby a real baby, a real person, which had the effect of detaching the baby from childhood conflicts even though we were unable to deal with those fantasies directly. And long before we were able to deal with the inner conflicts of Karen in our treatment, Nina, herself, began

to fulfill her mother's adolescent dream of renewal of self, a rebirth through giving birth to a child. Nina, through our work, became a loving intelligent, social little person who gave her mother huge rewards for motherhood. The mother who could not love herself or value herself when we first met her could know love and valuation from her child. Some measure of self-love could now grow in Karen, which means of course, that for Karen, as well as all parents, a loving and rewarding child brought enhancement of self-love, the healthy narcissism that is the privilege of all parents.

Nina's progress in treatment was far in advance of her mother's during the first two years. Nina was brought to adequacy on all measures of personality development by the time she was fourteen months old. But in this work we have two patients, a mother and a baby. As long as Karen's depression remained Nina was regarded by us as at risk and her mother's psychological state was regarded as precarious. When treatment was terminated at Nina's age three and a half, we were satisfied that Karen's internal conflicts had found resolutions and that Nina was sturdily progressing in her own development.

Therapeutic work with adolescent mothers and their babies needs to accomodate objectives for the treatment of two patients, each of whom may be suffering from a developmental disorder. This therapy has the aim of bringing optimal development for an adoles-

cent who is also an adolescent mother and for a baby whose development is endangered.

Notes

1. A full clinical report of this case and three other cases of adolescent mothers are included in Selma Fraiberg, editor, Clinical Studies in Infant Mental Health: The First Year of Life, Basic Books, Inc., New York, 1980.