2/13/79

Original now in
Ghosts In the Nursery

SF has seen & corrections made on this copy 10/13/78. 10-11-78

TO: SF

From: Laura

The Chicago Manual states that "exact numbers" of less than one hundred should be spelled out and numbers of one hundred or more should be expressed in figures. However, there is another clause in the sentence which reads, "in nonscientific text matter." Specific guidelines for "scientific" texts are not given for ages, which is of most concern to us.

Insights from the Blind followed a rule of having ages given in numerals, i.e., "5-month-old child," "she was 16 years old," etc.

My guess is that we follow the guideline given above for most instances--but give ages in numerals.

lh

(I'm aware of how unclear this sounds--reflecting my own lack of clarity about it. If you know who the publisher will be, we might give them a query.)

P. 8 P. 14 Corrected 10/13/

9/26/78

SF read & minor corrections - 10/3/78

JANE

Jane, who came to us at 5 1/2 months, was the first baby referred to our new Infant Mental Health Project. Her mother, Mrs. March, had appeared at an adoption agency some weeks earlier. She wanted to surrender her baby for adoption. But adoption plans could not proceed because Mr. March would not give his consent. Jane's mother was described as "a rejecting mother."

Now, of course, nobody loves a rejecting mother, in our community or any other, and Jane and her family might at this point have disappeared into the anonymity of a metropolitan community, perhaps to surface once again when tragedy struck. But chance brought the family to one of the psychiatric clinics of our University. The psychiatric evaluation of Mrs. March revealed a severe depression, an attempted suicide through aspirin, a woman so tormented that she could barely go about the ordinary tasks of living. The "rejecting mother" was now seen as a depressed mother. Psychiatric treatment was recommended at a clinical staffing. And then one of the clinical team members said, "But what about the baby?" Our new Infant Mental Health Project had been announced

and scheduled for opening the following day. There was a phone call to us and we agreed to provide immediate evaluation of the baby and to consider treatment.

Early Observations

From the time Jane was first seen by us we had reason for grave concern. At 5 1/2 months she bore all the stigmata of the child who has spent the better part of her life in a crib with little more than obligatory care. She was adequately nourished and physically cared for, but the back of her head was bald. She showed little interest in her surround, she was listless, too quiet. She seemed to have only a tenucus connection with her mother. She rarely smiled. She did not spontaneously approach her mother through eye contact or gestures of reach. There were few spontaneous vocalizations. In moments of discomfort or anxiety she did not turn to her mother. In our developmental testing she failed nearly all the personal-social items on the Bayley scale. The test could not be completed. Jane was badly frightened by the unexpected sound of the test bell. After only a few more items her threshold of tolerance was shattered and she collapsed into prolonged screaming.

The mother herself seemed locked in some private

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

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

Jane begins to cry. It is a hoarse, eerie cry in a baby. Mrs. Atreya discontinues the testing. On tape we see the baby in her mother's arms screaming hopelessly, she does not turn to her mother for comfort. The mother looks distant, self-absorbed. She makes an absent gesture to comfort the baby, then gives up. She looks away. The

screaming continues for five dreadful minutes on tape. In the background we hear Mrs. Adelson's voice, gently encouraging the mother. "What do you do to comfort Jane when she cries like this?" Mrs. March murmurs something inaudible. Mrs. Adelson and Mrs. Atreya are struggling with their own feelings. They are restraining their own wishes to pick up the baby and hold her, to murmur comforting things to her. If they should yield to their own wish they would do the one thing they feel must not be done. For Mrs. March would then see that another woman could comfort the baby, and she would be confirmed in her own conviction that she was a bad mother. It is a dreadful five minutes for the baby, the mother, and the two clinicians. Mrs. Adelson maintains composure, speaks sympathetically to Mrs. March. Finally, the visit comes to an end when Mrs. Adelson suggests that the baby is fatigued and probably would welcome her own home and her crib, and mother and baby are helped to close the visit with plans for a third visit very soon.

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

The Mother's Story

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

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

In late adolescence, Mrs. March met and married her husband, who came from poverty and family disorder not unlike her own. But he wanted something better for himself than his family had had. He became the first

member of his family to fight his way out of the cycle of futility, to find steady work, to establish a decent home. When these two neglected and solitary young people found each other, there was mutual consent that they wanted something better than what they had known. But now, after several years of effort, the downward spiral had begun.

There was a very high likelihood that Jane was not her father's child. Mrs. March had had a brief affair with another man. Her guilt over the affair, her doubts about Jane's paternity, became an obsessive theme in her story. In a kind of litany of griefs that we were to hear over and over again, there was one theme: "People stared at Jane," she thought. "They stared at her and knew that her father was not her father. They knew that her mother had ruined her life."

Mr. March, who began to appear to us as the stronger parent, was not obsessed with Jane's paternity. He was convinced that he was Jane's father. And anyway, he loved Jane and he wanted her. His wife's obsession with paternity brought about shouting quarrels in the home. "Forget it!" said Mr. March. "Stop talking about it! And take care of Jane!"

In the families of both mother and father illegitimacy carried no stigma. In the case of Mrs. March's clan, the promiscuity of their women over at least three or four generations cast doubt over the paternity of many of the children. Why was Mrs. March obsessed? Why the sense of tormenting sin? This pervasive, consuming sense of sin we thought belonged to childhood, to buried sins, quite possibly crimes of the imagination. On several occasions in reading the clinical reports, we had the strong impression that Jane was the sinful child of an incestuous fantasy. But if we were right, we thought to ourselves, how could we possibly reach this in our once-a-week psychotherapy?

Treatment: The Emergency Phase

How shall we begin? We should remember that Jane and Mrs. March were our first patients. We did not have treatment models available to us. In fact, it was our task in this first Infant Mental Health Project to develop methods in the course of the work. It made sense, of course, to begin with a familiar model in which our resident in psychiatry, Dr. Zinn, works with the mother in weekly or twice-weekly psychotherapy, and

the psychologist, Mrs. Adelson, provides support and developmental guidance on behalf of the baby through home visits. But within the first sessions, we saw that Mrs. March was taking flight from Dr. Zinn and psychiatric treatment. The situation in which she was alone with a man brought forth a phobic dread, and she was reduced to nearly inarticulate hours or to speaking of trivial concerns. All efforts to reach Mrs. March, or to touch upon her anxieties or discomfort in this relationship, led to an impasse. One theme was uttered over and over again. She did not trust men. But also, we caught glimpses in her oblique communications of a terrible secret that she would never reveal to anyone. She broke appointments more frequently than she kept them. With much difficulty, Dr. Zinn sustained a relationship with her. It was nearly a year before we finally heard the secret and understood the phobic dread that led to this formidable resistance.

There are no generalizations to be drawn from this experience. We have been asked sometimes if women therapists are more advantaged in working with mothers who have suffered severe maternal deprivation themselves. Our answer, after nearly eight years of work, is "not necessarily;

sometimes not at all." We have examples in our work in which the male therapist was specially advantaged in working with mothers. We tend to assign cases without overconcern about the sex of the therapist. Mrs. March must be regarded as an exceptional case.

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

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

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

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

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

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

in the mother's past. The method proved itself and led us, in later cases, to explore the possibilities of the single therapist in the home-based treatment.

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

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

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

baby, we would have to find a path into the conflictual elements of the mother's neurosis which had direct bearing upon her capacity to mother. The baby would need to be at the center of treatment for the emergency period.

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

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

This led us to our first clinical hypothesis: "<u>When this mother's own cries are heard, she will hear her child's cries.</u>"

Mrs. Adelson's work, then, centered upon the development of a treatment relationship in which trust

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

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

You remember that the baby was nearly always in

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

These were more than transitory gestures toward rapprochement with the baby. From all evidence to Mrs. Adelson's observing eyes, the mother and the baby were beginning to find each other. And now that they were coming in touch with each other, Mrs. Adelson did everything within her capacity as therapist and developmental

psychologist to promote the emerging attachment. When Jane rewarded her mother with a beautiful and special smile, Mrs. Adelson commented on it and observed that she, Mrs. Adelson, did not get such a smile, which was just the way it should be. That smile belonged to her mother. When a crying Jane began to seek her mother's comfort and found relief in her mother's arms, Mrs. Adelson spoke for Jane. "It feels so good when mother knows what you want." And Mrs. March herself smiled shyly, but with pride.

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

and with close watching, one could see how she was finding solutions and moving steadily forward. The delights of baby watching, which Mrs. Adelson knew, were shared with Mr. and Mrs. March, and, to our great pleasure, both parents began to share these delights and to bring in their own observations of Jane and of her new accomplishments.

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

Within four months Mary became a healthy, more responsive, often joyful baby. At our 10-month testing, objective assessment showed her to be age-appropriate in her focused attachment to her mother, in her preferential smiling and vocalization to mother and father, in her seeking of her mother for comfort and safety. The Bayley developmental testing showed uneven but impressive progress. Jane was 2 months advanced on social interaction items

and at age level for fine motor performance for her corrected age. Lags of from one to two months on vocalization and gross motor items placed her below her corrected age, but still within the normal range.

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

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

All this constitutes what we would call "the emergency phase of the treatment." Now, in retrospect, we can tell you that it took a full year beyond this point to bring some resolution to Mrs. March's very severe internal conflicts, and there were a number of problems in mother-child relationships which emerged during that year, but Jane was out of danger, and even the baby conflicts of the second year of life were not extraordinary or morbid. Once the bond had been formed, nearly everything else could find solutions.

Other Conflictual Areas

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

One poignant example comes to mind. Mrs. March, in spite of newfound pleasure and pride in motherhood, could still make casual and unfeeling plans for baby-sitting. The meaning of separation and temporary loss to a 1-year-old child did not register with Mrs. March. When mother took part-time work at one point (and the family poverty gave some justification for additional income),

Mrs. March made hasty and ill-thought-out sitting arrangements for Jane and then was surprised, as was Mr. March, to find that Jane was sometimes "cranky" and "spoiled" and "mean."

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

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

The moment came one morning when Mrs. Adelson arrived to find the family in disorder: Jane crying at the approach of a now familiar visitor, parents angry at a baby who was being "just plain stubborn." Thoughtful inquiries from Mrs. Adelson brought the new information that Jane had just lost one sitter and started with another. Mrs. Adelson wondered out loud what this might mean to

Jane. Yesterday she had been left, unexpectedly, in a totally new place with a strange woman. She felt alone and frightened without her mother, and did not know what was going to happen. No one could explain things to her; she was only a baby, with no words to express her serious problem. Somehow, we would have to find a way to understand and to help her with her fears and worries.

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

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

She cried throughout, but somehow, even with Mrs. Adelson's gentle hints, she could not put this together.

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

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

Jane wouldn't have any way to understand this; it would leave her very worried, very upset. I wonder what it was like for you when you were a little girl."

Mrs. March listened, deep in thought. A moment later she said, in an angry and assertive voice, "You can't just replace one person with another....You can't stop loving them and thinking about them. You can't just replace somebody." She was speaking of herself now. Mrs. Adelson agreed, and then gently brought the insight back on behalf of Jane.

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

Finally, too, we learned the dreaded secret which had invaded the transference to Dr. Zinn and caused her to take flight from psychiatric treatment. The morbid fear of being alone in the same room with the doctor,

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

Jane at 2 Years of Age

During the second year of treatment, Mrs. Adelson continued as the therapist for Mrs. March. Dr. Zinn had

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

It is of some considerable interest that in the initial meetings with Mr. Schafer, Mrs. March was again in mute terror as her morbid fear of "a man" was revived in transference. But this time Mrs. March had made large advances in her therapeutic work. The anxiety was handled in transference by Mr. Schafer, and brought back to Mrs. Adelson where it could be placed within the context of the incestuous material that had emerged in treatment. The anxiety diminished, and Mrs. March was able to make a strong alliance with Mr. Schafer. The developmental guidance of the second year brought further strength and stability to the mother-child relationship, and we saw Jane continuing her developmental progress through her second year, even as her mother was working through very painful material in her own therapeutic work.

Were there residues in Jane's personality from the early months of neglect? As a 2 year old, Jane was an

attractive, busy little girl who presented no extra-ordinary problems in development. The only residue we could detect was a momentary stoppage of play at times when Mrs. March became temporarily uncomfortable, as in an unfamiliar social setting or when recalling particularly painful memories.

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

It was in doll play at 1 year, 10 months that Mr. Schafer first heard her speak a full sentence. Her doll was accidentally trapped behind a door with a spring catch, and Jane could not recover it. "I want my baby.

I want my baby!" she called out in an imperative voice. It was a very good sentence for a 2 year old. It was also a moving statement to all of us who knew Jane's story.

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