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Infant-Parent Psychotherapy on Behalf of a Child

In a Critical Nutritional State

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delete - authors are identified elsewhere.

P.I.

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In this paper we describe the treatment of an infant ^{Billy} boy who was referred to our Infant Mental Health program at 5 months of age in a grave nutritional state. The baby was starving. His growth curve showed an ominous downward plunge which our pediatricians read as the profile of an infant who was moving toward the critical (and sometimes irreversible) state which is broadly covered by the term "failure to thrive." * The term "failure to thrive" describes those infants who show growth failure in the absence of any organic cause. In strict usage it is employed for infants whose weight has fallen below the third percentile. It is almost universally associated with the impairment of the mother's capacity to nourish both in the concrete and in the psychological sense of the word.

The typical course of medical treatment for a failure-to-thrive infant is hospitalization with intensive one-to-one nursing care. With nurse-mothering and the introduction of a good nutritional regime, the baby begins to thrive. When his nutritional state is stabilized, he returns to his home. Typically, these gains are lost within a few weeks and the baby may return to

* A summary of the literature on failure to thrive appears in the introduction to the case of Nina (Chapter —

the hospital again--and the cycle renews itself.

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

required to avoid such injury to the parent" (p. 644).

In evaluating their experience, Barbero and Shaheen conclude: "Early case-finding and diagnosis are vital links in the process of intervention" (p. 644).

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

~~As has been decided in ch. 2 & 3,~~

Our Infant Mental Health Program brings the skills of a psychiatric team into the home. Clinical assessment of the child and his family and close collaborative work among the clinical specialists on our staff are carried out within the framework of home visits. The treatment program which evolves is provided by one primary therapist who may be a social worker, a clinical psychologist, an educational specialist, a pediatric nurse, or a psychiatric resident. The therapy is conducted in the family living room (or the kitchen). The baby as patient is usually present with one or both of his parents. The sessions are, of course, focused upon

Treatment
Methodology?

✓ This case, involving an infant in critical nutritional and psychological state ~~since he depressed who cannot see them~~ was one in which therapist ^{help} ~~employed~~ ^{employed} an approach including supportive guidance & interpretive infant (parent) psychotherapy. A summary of these methods. The general theme of this methodological approach has been decided in ch. 3. ~~This approach~~ ^{summary}.

the baby and his development, the parental concerns, and inevitably the conflicts which are impeding the parent in his or her relationship with the baby. Our concerns for the parent as well as the baby have made us welcome visitors to many "hard-to-reach" families.

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

Our work is guided by psychoanalytic principles and two of our senior staff members are child psychoanalysts who participate in the case review and planning in all intensive treatment cases. However, the treatment program for each family is properly speaking a collaboration

of disciplines in which social work, clinical psychology, developmental psychology, special education, pediatrics, medicine, and nursing are united with psychoanalysis in every phase of the work.

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

BILLY AT 5 MONTHS

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

Kathis Douglas was an anxious 17-year-old girl who

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

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

CLINICAL EVALUATION

Our first task, then, during this medical emergency, was to make a psychological assessment of Billy and his family. ^{As therapist 9.} ~~The therapist~~ began twice-weekly visits to the home for direct observation of the baby, his parents, and their modes of interaction.

Under all ordinary circumstances we devote approximately 5 weekly one-hour sessions to the clinical evaluation period. In Billy's case, the nutritional and psychological perils were so great that we knew, after the first three visits, (1-1/2 weeks), that intervention on a concrete educational basis must begin before the psychological complexities were fully understood. These earliest visits, however, gave us vital clues which we could pursue in the emergency period.

Initial Observations of Billy and His Parents

When ⁹ ~~the~~ therapist first arrived at the Douglas's small apartment, ⁹ ~~she~~ met a timid, sad-faced 17-year old girl, who was Billy's mother, and a gaunt young man, ^{Billy's} ~~the~~ father, barely out of his teens, who was so uneasy

4. V.S. is therapist

that he did not acknowledge ^{my} her presence until almost the end of this visit.

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

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

Billy seemed unusually aware of sounds. In particular, his mother commented that Billy responded quickly to any sounds related to feeding. She illustrated this by opening the refrigerator door while Mr. Douglas held the baby. Billy almost jumped out of his father's arms, his mouth opened, anticipating food, and his whole body strained toward the refrigerator. As his mother

approached him with an eyedropper with vitamins, Billy, still in his father's arms, leaned back, opened his mouth, his hands became inert, and he looked like a starving baby bird awaiting food from his mother. Mother and father seemed uncomfortable with Billy. They treated him like a newly arrived stranger whom they had to approach cautiously and from a distance.

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

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

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

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

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

In response to ^{my} ~~the~~ therapist's comment that this year must seem different from last year when she was still at school, Kathie spoke of her feelings of loss. She missed her hometown, her high-school friends. She missed going to school. So much was unfinished and now everything had come to an end. In her mind Kathie was not Mrs. Douglas, she was a misplaced teenager keeping house. All this emerged in a sad and distant voice. The therapist was struck by the depth of Kathie's depression, which was evident in her posture as well as in her words. Her range of affect was constricted. Her movements were slow. Her speech was halting, and she seemed distant and sometimes confused. She rarely made eye contact with ^{me} ~~the~~ therapist.

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

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

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

How Is Billy Fed?

As part of our assessment a video play session was arranged at our office playroom.¹

This session was primarily planned so as to permit the baby's own play as well as spontaneous mother-baby interaction. What occurred gave us a sobering picture of the isolation and the estrangement of baby and mother. As if ^{he} ~~her~~ were alone in the room, the baby engaged in

¹We customarily videotape a play session and Bayley testing at this point in an assessment. This is done only with the consent of parents, of course, and we do everything possible to make the taping nonintrusive. We never invite intimate discussions at these times. We do not use video for treatment sessions, but we find that the taping of play sessions and testing is almost always of great interest to parents, and the playback of the tapes for the parents is valued by them and by us as an opportunity to observe the baby and themselves. In Billy's case because of the urgency of the feeding problem, a formal Bayley testing was postponed until nutritional adequacy was achieved at 7-1/2 months.

solitary exploration of toys and furniture. He never once sought his mother with his eyes. He was mobile, but never crept toward his mother. His mother looked distant and selfabsorbed.

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

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

After a while the therapist suggested that Mrs.

Douglas sit with Billy in our rocking chair and feed him. The second observation gave us another piece of the puzzle. Kathie now held Billy loosely in her arms. Billy was still supporting his own bottle. The mother, looking tired and apathetic, said that Billy usually finished his bottle in 4 minutes. "Sometimes, however, if the bottle is slow, it takes an hour." She talked as though it were his feeding, not something that she had anything to do with. She herself looked distant and empty. Our impression was that although Billy was in his mother's arms, he was still feeding himself. There was no mutual gaze, and little tactile contact. The mother is right: the baby turned away from her. She looked uneasy and sad and sometimes irritated.

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

that this was in fact a good feeling, a better feeding than usual.

Why Can't Kathie Feed Her Baby?

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

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

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

No case report can ever do justice to the feelings of the therapist who works with infants and their parents. There is an urge to rescue the baby who is in danger, to mother him oneself. There are deep reproaches, even anger toward the schoolgirl who is starving her baby, which must ^{not} be expressed and which must be dealt with by the therapist lest it intrude in the work. In this situation we were helped by the fact that all of us are child therapists. We saw the mother herself as a child, an unfinished adolescent who still needed a mother herself. She was frightened, helpless, hungry, depleted. This did not imply that ^{9 the} the therapist must become a mother or a mother substitute, but if we understood the child who was the mother and responded to her feelings of anguish and deprivation, we might earn her trust. Only on this basis was there

hope for treatment.

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

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

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

Thereafter Kathie could tell us more. She had noticed that when Billy was 3 months old and had begun taking solids in his diet, the hue and texture of the vomit had changed. She was so repelled that she reduced Billy's solids to a minimum as a way to avoiding the revolting mess. We now had another vital clue: the decline in Billy's weight curve had started at 3 months.

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

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

Assessment and Intervention Plan for the Emergency Period

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

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

was an adolescent with unsatisfied bodily and psychological hungers.

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

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

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

could not wait for the resolution of his mother's neurosis.

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

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

THE EMERGENCY PERIOD OF TREATMENT

The period that we speak of as "emergency treatment" lasted for 2 months. It is really synchronous in time with the assessment period. During this period Billy

began to eat normally, the vomiting virtually ceased, and he began to gain weight in a stable and satisfactory manner.

The Therapeutic Relationship

^{I will briefly}
The therapist summarizes the clinical work of this period which helped mother resolve some aspects of the feeding problem.

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

^I
The therapist found out very quickly that if she responded to Kathie's own needs and feelings, either covertly or overtly expressed by her, Kathie would soon, and often in the same session did, attend to some of Billy's needs. For example, ^{when} the therapist acknowledged that ^I she understood how hard it was for

Kathie to try and hold a baby who turned away, Kathie was able to hold Billy with tears in her eyes instead of putting him down.

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

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

continue her artwork.

We knew that Kathie felt inadequate, had been told she was by her mother, and in a sense by Billy himself as he repeatedly seemed to reject her food. The therapist¹ was very careful not to compete with Kathie in any way for Billy's attention, nor did ~~she~~⁹ actually intervene and do things for Billy, even though at times ~~she~~¹ could hardly restrain herself. It was important for Kathie to feel that ~~the~~¹ therapist, as a child consultant, identified with her as a mother facing problems in caring for her baby and that ~~she~~¹ had confidence that Kathie, with ^{my} her help, could give Billy what he needed to be a healthy baby. Together they ^{we deserved} observed Billy, his preferences and his dislikes, and took joy in any of his accomplishments. Billy's accomplishments were always related back to Kathie's efforts. The therapist⁹ especially shared ^{my} her observations with Kathie of any special feeling that Billy expressed toward her, as his mother, such as a preferential smile or a reaching out to her. Kathie's feeling of failure was so strong that she was amazed when Billy preferred to go to her rather than ^{to me} to the therapist. She clung to any bit of evidence that Billy liked her. When she saw the scene

of herself in the rocking chair with Billy, she said,
 "That looks so peaceful, Billy looks so contented."

Guidance: Infant Nurture and Mother Nurture

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

The first concrete changes came in Kathie's willingness to try to hold Billy for a feeding. Kathie had said that Billy did not like to be held, she knew this because he turned away. ~~The therapist~~ commented that even though Billy turned away, his body seemed to be more relaxed and ~~she~~ thought this indicated that he did like his mother to hold him. It was obvious that Kathie's bland, sad face could not hold Billy's attention when she was trying to feed him in her arms. One time, as ~~the therapist~~ watched Kathie try to feed Billy in her arms, Billy repeatedly turned away. Seeking a tactful way to guide Kathie to a livelier exchange with

her baby, ~~the~~ therapist asked her if she ever told Billy stories. She said, "No." ~~The~~ therapist asked if ~~she~~ could tell Billy a story while Kathie held him and she agreed. ~~The~~ therapist began ^{my} her story, "Once upon a time there were three bears," using what Stern (1973) describes as "normal baby talk expression," elongation of smile, rise and fall of voice, exaggerated nuances. All of these are typical exchange behaviors between baby and mother. All were missing from Kathie's conversation with Billy.

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

A major concern was the burping process. ~~The~~ therapist had made many suggestions to Kathie about burping Billy, and had tried to help Kathie understand how her method would precipitate vomiting. It was only when ~~the~~ therapist actually stood beside her, however, and shared with her

the tension she was feeling, as she put Billy gently over her shoulder with the diaper underneath him, that she was gradually able to begin burping Billy in a normal fashion.

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

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

The therapist ^{I was able to} ~~could~~ use the positive transference in supporting Kathie step by step in a feeding program for Billy. It was futile, of course, to challenge Kathie's irrational belief that Billy would "eat the family out of house and home" or that he would "throw up endlessly." The therapist only sympathized with Kathie's

fears and led her gently into a collaboration on Billy's behalf.

With pencil and paper and measuring cups ~~the therapist~~
⁺⁹ and Kathie ¹ worked out quantities and sample feedings.
 We soon saw that Kathie could follow this regime. Long
 afterward we are still wondering how this was possible
 in view of the fact that quantities of food were still
 bound to profound conflicts in Kathie. Our best guess
 is that the objective, "on paper" feeding plan relieved
 Kathie of the responsibility for dealing with her own
 unconscious and dangerous impulses toward her baby.
 The ~~therapist~~, "siding with the ego," ^{9 as therapist} was lending her ^{my}
 own quiet authority to support Kathie's positive strivings
 to mother and her defenses against the destructive wishes.

In many discussions ^{with me} ~~with the therapist~~, Kathie
 expressed her fear and revulsion of Billy's throwing
 up. The ~~therapist~~ ⁹ acknowledged that ~~she~~ ⁹ could understand
 how especially difficult it was for Kathie to hold and
 feed Billy. ~~She~~ ⁹ told Kathie that together ^{we} ~~they~~ would pay
 special attention to ensure that Billy would not throw
 up through overeating and that ~~she~~ ⁹ wanted Kathie to observe
 carefully how much he ate and whether or not he threw up.
 With much relief that ~~the therapist~~ ⁹ understood her

difficulty, Kathie agreed to place Billy on a solid feeding schedule, which she and the ⁹therapist monitored carefully.

Billy began to gain weight steadily. Vomiting virtually disappeared. By 7 months Billy had gained 2-1/2 pounds and reached the 50th percentile in weight; ^{The pediatrician} Dr. Larson was satisfied that Billy was no longer in nutritional peril.

The Family's Progress

During the time this work was progressing, we were, of course, concerned with the well-being of the whole family, Mr. and Mrs. Douglas and Billy. An important part of work was the help that was given Mr. Douglas. He came from a large, impoverished family and had suffered physical and emotional privations in his own childhood. As a young husband and father he was again struggling with poverty and hunger, and his depressed young wife drained his emotional resources. Each member of the family was hungry for physical and emotional sustenance. When John was home, he, too, shared his worries with ^{me} the therapist, ^{and I} who responded with sympathetic understanding and with attention to his problems. ~~She~~ ⁹

helped John and Kathie find ways to work out their present financial difficulties. ⁹ She let them know that their hunger was her concern as well.

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

THE EXTENDED TREATMENT PHASE

Reassessment

The period that we speak of as the extended treatment phase carried the work with Billy and his parents for a full year beyond the emergency period. While Billy had made progress, we still regarded him as a baby "at risk" in the psychological sense.

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

need, he still cried helplessly and piteously.

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

As part of our continuing assessment, when Billy was 7-1/2 months old, we videotaped another playroom visit which included a Bayley Developmental Assessment and a spontaneous feeding.³ This tape spoke eloquently for

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

the mother's ambivalence toward her baby and for pathological tendencies in both.

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

We have learned to give such "baby games" serious clinical attention. Some of our most important clinical insights have been derived from observing parents at play with their babies. The parent in conflict frequently reveals the essence of the conflict in play, in the "harmless games" (Fraiberg, 1974).

What we saw on tape, then, was a young mother competing with her own baby for his bottle. The moments of tender mothering were interrupted by an intruding thought, and feeding the baby became "teasing the baby," "taking food out of his mouth," "jealousy," "competition." As we

watched this tape as a staff, we were struck by the thought that the mother behaved as if her baby were a sibling--at that point the story began to come together for us.

The Ghost in Billy's Nursery

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

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

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

The Infantile Conflicts and Repetitions in the Present

Our treatment during this period united guidance on behalf of Billy and a therapy which explicitly focused on Kathie's conflicts in mothering and their origins in her own childhood conflicts.

The setting remained the same: home visits, scheduled twice weekly. Kathie was a willing and eager collaborator in her own treatment, to find out "why" she felt herself the victim of her own past.

Typically, the sessions would begin with Billy in the living room or the kitchen, and ~~the therapist~~ and Kathie + 9 would speak about ^{Billy's} ~~his~~ progress, or discuss any of Kathie's questions. The ~~therapist~~ ⁹ continued, of course, to offer ^{my} ~~her~~ observations and to help Kathie observe Billy, to interpret his needs and his signals, to praise his accomplishments and her own growth as a mother. Kathie's own needs for the ~~therapist's~~ ^{my} time sometimes brought her into competition with Billy. Billy always had "his" time, during part of each session, and sometimes when Kathie felt most urgently in need of time with ~~the~~ therapist, she would say, "Shh, Billy, it's my turn now." Usually, the visits were timed so that Billy's nap would divide the time and give Kathie some time for privacy.

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

The transference was employed both to open up the past and to offer Kathie, the "unfinished adolescent," a new figure for identification and for undoing the powerful effects of her own mother, remembered as

rejecting, critical, suspicious, and harsh, the "witch-mother" of early girlhood and adolescence.

The flow of memories converged again and again on the time following the birth of Essie, a period which marked a profound shift in Kathie's relationship to her own mother. Allowing for much distortion in adolescent memory, the figure of Essie, the baby who robbed Kathie of her mother, and the figure of the mother who "rejected" Kathie for the new baby were persistent ghosts. Along with these memories came overwhelming feelings of grief, depression, mourning for herself as a neglected, unwanted child. These were the feelings which had been revived with the birth of Billy. In Kathie's living room, with her own baby, the therapist⁹ often had the eerie feeling that she⁹ was witnessing another time, that Kathie was again the bereaved 5-year-old robbed for the second time by a baby. Motherhood had brought regression, and Kathie was locked once again in the infantile conflict.

^{therapeutic}
The relationship with the therapist opened up many pathways for "undoing."

"My mother never listened to me," was Kathie's reproach, a recurrent theme in these hours, but the therapist⁹

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

When muted or sullen anger appeared in the transference, the therapist helped Kathie put her anger into words and to discover that the anger would not destroy the ^{no} therapist, or the positive relationship ^{we had developed} to the therapist, and could, indeed, open pathways to the conflicted past

and ways to find meaning in that anger.

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

Kathie, Essie and Billy

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

As memories of Essie emerged with rage toward that first baby "who spoiled everything," and as grief for herself as a small girl was revived, we began to see, for the first time, a spontaneous reaching out to Billy. ~~The therapist describes~~ ^{is described} This in an excerpt from a visit with Kathie when Billy was 8 months old:

I had asked Kathie if she could tell me what it was like for her when her own baby sister was born. She said, 'I've told you I hated my sister, how she always came between me and my mother. I don't remember much. When my sister was little, I remember being outside of

the house much of the time. I do remember a couple of things. I didn't want to play with her. I hated to be told to play with her and I told my father that I hated her.'

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

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

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

In this excerpt, then, we see that as Kathie reexperiences the rage toward Essie, she can turn toward her own baby and spontaneously show her affection for him. She plays a game with him with full enjoyment, and we recall the words she had used in the early part of this session when she spoke of Essie, "I didn't want to play with her. I hated to be told to play with her." As the affective pathways lead back to Essie, Kathie is able to disengage Billy from the first intruder and, as if some preconscious association had taken place around "play," she gives the "no" to Essie and the "yes" to Billy. Where Kathie's mother "didn't understand" and both parents sternly prohibited the expression of anger toward Essie, the therapist understood and accepted the words, "I hated her." The play with Billy was also, then, a gift to the therapist. *me, her therapist.*

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

feelings from Essie to Billy.

The ghost of Essie appeared in many disguises. For weeks the therapist⁹ was puzzled by a complaint from Kathie: Billy, Kathie said, drove her to distraction when he followed her around the house.

From the therapist's^{my} point of view, Billy's following of mother and touching base with her were a most welcome signs of the growing attachment between Billy and his mother. Kathie found it nearly intolerable and took a dim view of the therapist's^{my} ideas on the subject.

Then, in an interview, when Billy was 8-1/2 months old, Kathie quite unconsciously provided the vital clue.

^{Kathie} The therapist again describes the session when Kathie was expressing a tirade against Essie:

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

After a few moments I asked her what it was like for her when Billy followed her around the house. Kathie said, 'It's entirely different.' Then she laughed. She understood. Kathie went to Billy and picked him up. She cuddled him, and put him on her lap so that he was lying on her knee, and tickled his back until Billy was laughing and giggling. He seemed delighted.

With this new insight, Kathie could now use more of the developmental and guidance information that ~~the~~ ^{was} therapist offered. For example, regarding Billy's following her, ~~the~~ ⁹ therapist explained that he wanted to keep her in sight at home because he was attached to her. At 8 months mother's presence was reassuring. As Billy grew, he would be able to remember her presence even if she was in another room. He would not have to follow her all the time.

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

However, although the teasing games with Billy receded during this period, ~~the~~ ⁹ therapist still caught glimpses

of "teasing" which concerned us. On an educational level the therapist⁷ had dealt directly with the teasing games during feeding. She⁷ pointed out that these were games which might lead to problems which Kathie would not really want to see in Billy. She⁷ spoke of the meaning that food and love had for babies as well as adults. What did these games mean to Billy? Kathie consciously made an effort to give up the teasing games, an effort which was partially successful, yet the urge to tease Billy broke through in a game, and more explicitly, in withholding food from Billy when he was manifestly hungry, Kathie responding only to his most urgent cries.

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

mother. Kathie, encouraged by ^{me} ~~the~~ therapist, repeated the game until finally Billy rewarded his mother by smiling and cooing, but still turned away from her. The ⁹ ~~therapist~~ interpreted the smiling and vocalizing as his way of telling mother he enjoyed the game. Perhaps soon he would also give her the reciprocal gaze she so wanted as affirmation of his affection toward her. Kathie, we saw with sadness for her plight, had to work very hard to woo her baby after the many months of avoidance and neglect.

Then, when Billy was 11 months old, the meaning of the teasing games and a facet of Kathie's uncontrollable urge to inflict pain broke through in a session. The ~~2~~ therapist ~~summarizes the critical material:~~

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

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

here."

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

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

Kathy was so caught up in feelings of rage toward her sister, that without thinking she reached and grabbed Billy's arm and began shaking him angrily saying

without being aware of it At this moment she turned to Billy who was playing on the floor, and took his arm and showed me how she would shake her sister, saying, 'I would shake her like this and like this.' Billy started to cry, obviously scared. *His tears and my concern brought Kathie back to the present. She* I was scared for him. Kathie stopped abruptly. She was shocked and said, 'Sorry Billy, I didn't mean to hurt you.'

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

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

Thus the teasing and sadistic rage toward Essie emerged from memory and could also be observed in a direct displacement toward Billy. After many

interpretations, in this visit and others, of the repetition of feelings from the past in the present, Kathie's quick denial finally gave way to affirmation and insight.

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

Kathie and Her Mother

The competitiveness with Billy was only one of the many themes that appeared throughout the work with Kathie. There was another important theme. We had often observed her seeming indifference to Billy's cries. Many times it seemed as if she and Billy were crying together. There was no mother present in the room. With

great sadness and anger Kathie would say that her mother had not understood her. Once again ~~the therapist~~ ⁹ acknowledged that Kathie too had many needs to be heard, to be loved, and to be understood and nurtured.

~~The therapist~~ ⁹ asked many times what it was that Kathie most wanted her mother and perhaps ~~the therapist~~ ^{me} to understand. Gradually her true feelings emerged. She did not want to be a mother, she had never wanted to be a mother, and she was not ready to give up her role as a child. She had in fact not really separated from her own family.

With great sadness Kathie told ~~the therapist~~ of the very painful relationship she had had with her own mother. She felt that her mother was never satisfied with her, especially as a daughter. Kathie said that she had always been the family boy, loved by her father and ridiculed by her mother. As a little girl she had never played with dolls, but had always preferred to play with the neighborhood boys. As she approached puberty, she was accused by her mother of being too seductive. Nothing she did was right. With great hurt she described how her mother had said that she could never be as pretty as her older sister or as good as

the younger sister. She began to go out with John, whom her mother had liked. During this time Kathie's mother had begun to enter menopause and was wishing explicitly for a grandchild. Kathie's older sister did not have any children. Kathie got pregnant and had Billy. Kathie, with hurt and anger, said that now her mother had a grandchild, but for her Billy's birth was not all that it was supposed to have been. The fantasy of renewed babyhood for Kathie never materialized. Now that Billy was born, he was the grandparents' pride, not Kathie. She was only 17 and faced with an entirely new role, that of motherhood, which she did not want.

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

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

At first ^{Kathie} she was unable to interpret Billy's cries and ~~the~~ ⁹ therapist would talk for him. For example, many times Billy was in his playpen and wanted to get out. Kathie was unable to respond. ~~The~~ ⁹ therapist would talk for Billy and say, "Mom, I'm trying to tell you that I want out of the playpen, but I don't have any words yet." Kathie would respond. They had many discussions about the ways in which Billy tried to communicate with her without words. When Kathie did respond, ~~the~~ ⁹ therapist always rewarded her efforts, speaking for Billy, who was not yet able to show her that he appreciated her efforts. ~~The~~ ⁹ therapist might say, "Isn't it good to have a mommy who hears you and understands you? Even mommy has to be understood."

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

that she knew Billy better, and the therapist, of course, stepped back from the role of active interpreter.

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

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

TERMINATION OF TREATMENT AND FOLLOW-UP

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

brought financial security to the family.

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

There were no residual feeding problems; Billy at 12 months and at the follow-up (25 months) was a child who enjoyed food. He had no food idiosyncrasies or conflicts with his mother around feeding. There were no symptoms or disorders in the areas of orality or beginning autonomy. We watched carefully for signs of affective disturbances and saw none. We worried about possible residues from the sadomasochistic feeding games, which had so concerned us when Billy was 8 months old, but we could identify no sequela in the second year behavior picture. We did observe that John still occasionally teased Billy in words or games (Kathie did not) and that Billy at these times did not participate in these games, but turned away from his father, typically moving toward other games or toys. (We wish that we could have provided more help to John in this area, but we are satisfied that Billy did not offer

himself as a partner in such games.)

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

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

The therapeutic work with Kathie succeeded in freeing her and Billy from those aspects of a conflicted childhood which were being reenacted between her and her baby. To some measure, we believe, the work also resulted in the completion of Kathie's own adolescence. The resolution of infantile conflicts between Kathie and her mother freed her to become a mother and a wife in her own rights. For

not only did Kathie become a mother who enjoyed her child, but we saw many positive changes in her relationship to her husband, and the marriage gained stability.

When Billy and his parents were seen in follow-up at 25 months, we were satisfied that he and his parents had sustained the gains of treatment. With only minimal ^{therapeutic} support and guidance ~~from the therapist~~ during the period that followed their move from our community, both parents showed growth as young adults and had brought wisdom and good judgment to their rearing of Billy. They were justifiably proud of Billy and his achievements and spoke tenderly of his affectionate nature and his endearing ways of greeting his parents when he woke each morning.

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

Recalling Kathie's earlier revulsion toward vomiting and messiness, we were interested to see that none of this had carried over to the toilet training of Billy. Since our work had not dealt with the deeper layers

of this revulsion in Kathie, we wondered why the area of toilet training had not been contaminated. Then ~~the~~ therapist remembered that throughout the early critical period of the treatment, ~~she~~ ^{she} had observed many diaperings of Billy, but at no time had Kathie shown revulsion toward the baby's feces or cleaning the anal region. It was, then, specifically an oral revulsion on Kathie's part, in which food and vomit may have had anal determinants, but were curiously not manifest in connection with anal functions.

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

Post Script.

Three years later, when Billy was 5, the family ^{came to see me at} recontacted CDP ~~Therapist~~ ^{Therapist} ~~to~~ ^{to} Billy had entered kindergarten and the proud parents wanted to share their pleasure with me. Billy ~~was~~ ^{was} ~~the~~ ^{was} ~~her~~ ^{her} ~~home~~ ^{home} ~~At school~~ ^{At school} Billy was apparently an outstanding student. The teacher had wanted to know whether he had attended a preschool program ^{that} ~~that~~ ^{he had attended} that accounted for his ^{social} and intellectual abilities. His mother proudly told me - "I was the pre-school program" - Billy was tall, handsome, warm, alert, and with a twinkling eye and good sense of humor. His parents had ~~been~~ ^{been} ~~obviously~~ ^{obviously} ~~continued to grow as people themselves, and used this visit to review~~ ^{continued to grow as people themselves, and used this visit to review} ~~as young adults,~~ ^{as young adults,}

Wanted,
There was an opening and the + between Billy & his parents
that was delightful to see. ^{In the end it was apparent that} The parents ~~had~~ Rather of I know
had worked hard to ^{successfully} continue their son as young adult, and
had ~~succeeded despite hard times, to reach a satisfying~~
~~their relationship seemed~~ The parents spoke gratefully of the
help they had received almost 5 years ago, which they
realized had enabled them all to come through a most
difficult time. They spoke of the cop ~~They said themselves~~
~~parents with more recent understanding of the~~ Most of all they
enjoyed Billy tremendously, and he obviously felt good about
himself & about himself!