Ghosts in the Nursery

A Psychoanalytic Approach to the Problems of Impaired Infant-Mother Relationships

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In every nursery there are ghosts. They are the visitors from the unremembered past of the parents; the uninvited guests at the christening. Under all favorable circumstances the unfriendly and unbidden spirits are banished from the nursery and return to their subterranean dwelling place. The baby makes his own imperative claim upon parental love and, in strict analogy with the fairy tales, the bonds of love protect the child and his parents against the intruders, the malevolent ghosts.

This is not to say that ghosts cannot invent mischief from their ancient places. Even among families where the love bonds are stable and strong, the intruders from the parental past may break through the magic circle in an unguarded moment, and a parent and his child may find themselves reenacting a moment or a scene from another time with another set of characters. Such events are unremarkable in the family theater, and neither the child nor his parents nor their bond is necessarily imperiled by a brief intrusion. It is not usually necessary for the parents to call upon us for clinical services.

In still other families there may be more troublesome events in

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This paper is dedicated to the memory of Beata Rank who asked the questions and sought the methods which illuminated the first years of life.

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the nursery caused by intruders from the past. There are, it appears, a number of transient ghosts who take up residence in the nursery on a selective basis. They appear to do their mischief according to a historical or topical agenda, specializing in such areas as feeding, sleep, toilet training, or discipline, depending upon the vulnerabilities of the parental past. Under these circumstances even when the bonds between parents and child are strong, the parents may feel helpless before the invasion and may seek professional guidance. In our own work, we have found that these parents will form a strong alliance with us to banish the intruders from the nursery. It is not difficult to find the educational or therapeutic means for dealing with the transient invaders.

But how shall we explain another group of families who appear to be possessed by their ghosts? The intruders from the past have taken up residence in the nursery, claiming tradition and rights of ownership. They have been present at the christening for two or more generations. While no one has issued an invitation, the ghosts take up residence and conduct the rehearsal of the family tragedy from a tattered script.

In our Infant Mental Health Program we have seen many of these families and their babies. The baby is already in peril by the time we meet him, showing the early signs of emotional starvation, or grave symptoms, or developmental impairment. In each of these cases, the baby has become a silent partner in a family tragedy. The baby in these families is burdened by the oppressive past of his parents from the moment he enters the world. The parent, it seems, is condemned to repeat the tragedy of his childhood with his own baby in terrible and exacting detail.

These parents may not come to us for professional guidance. Ghosts who have established their residence privileges for three or more generations may not, in fact, be identified as representatives of the parental past. There may be no readiness on the part of the parents to form an alliance with us to protect the baby. More likely, we, and not the ghosts, will appear as the intruders.

Those of us who have a professional interest in ghosts in the nursery do not yet understand the complexities and the paradoxes in the ghost story. What is it that determines whether the conflicted past of the parent will be repeated with his child? Is morbidity in the parental history the prime determinant? This strikes us as too simple. Certainly we all know families in which a parental history of tragedy, cruelty, and sorrow have *not* been inflicted upon the children. The ghosts do not flood the nursery or erode the love bonds.

Then, too, we must reflect that, if history predicted with fidelity, the human family itself would have long ago been drowned in its own oppressive past. The race improves. And this may be because the largest number of men and women who have known suffering find renewal and the healing of childhood pain in the experience of bringing a child into the world. In the simplest terms—we have heard it often from parents—the parent says, "I want something better for my child than I have had." And he brings something better to his child. In this way we have all known young parents who have suffered poverty, brutality, death, desertion, and sometimes the full gamut of childhood horrors, who do not inflict their pain upon their children. History is not destiny, then, and whether parenthood becomes flooded with griefs and injuries, or whether parenthood becomes a time of renewal cannot be predicted from the narrative of the parental past. There must be other factors in the psychological experience of that past which determine repetition in the present.

In therapeutic work with families on behalf of their babies, we are all the beneficiaries of Freud's discoveries before the dawn of this century. The ghosts, we know, represent the repetition of the past in the present. We are also the beneficiaries of the method which Freud developed for recovering the events of the past and undoing the morbid effects of the past in the present. The babies themselves, who are often afflicted by the diseases of the parental past, have been the last to be the beneficiaries of the great discoveries of psychoanalysis and developmental psychology. This patient, who cannot talk, has awaited articulate spokesmen.

During the past three decades, a number of psychoanalysts and developmental psychologists have been speaking for the babies. What the babies have been telling us is sobering news, indeed. This story you already know, and I shall not attempt to summarize the vast literature which has emerged from our studies of infancy.

In our own work at the Child Development Project, we have become well acquainted with the ghosts in the nursery. The brief intruders, which we have described, or the unwelcome ghosts who take up temporary residence, do not present extraordinary problems to the clinician. The parents themselves become our allies in banishing the ghosts. It is the third group, the ghosts who invade the nursery and take up residence, who present the gravest therapeutic problems for us.

How is it that the ghosts of the parental past can invade the nursery with such insistency and ownership, claiming their rights above the baby's own rights? This question is at the center of our

work. The answers are emerging for us, and in the closing section of this essay we shall return to the question and offer a hypothesis derived from clinical experience.

In this paper, we shall describe our clinical study and treatment through two of the many imperiled babies who have come to us. As our work progressed, our families and their babies opened doors to us which illuminated the past and the present. Our psychoanalytic knowledge opened pathways into understanding the repetition of the past in the present. The methods of treatment which we developed brought together psychoanalysis, developmental psychology, and social work in ways that will be illustrated. The rewards for the babies, for the families, and for us have been very large.

In our collaborative work, Edna Adelson, staff psychologist, was the therapist for Mary and her family, Vivian Shapiro, staff social worker, was therapist for Greg and his family, and Selma Fraiberg served as case supervisor and psychoanalytic consultant.

Mary

Mary, who came to us at 5½ months, was the first baby referred to our new Infant Mental Health Program. 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. Mary's mother was described as "a rejecting mother."

Now, of course, nobody loves a rejecting mother, in our community or any other, and Mary 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 Program 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 Mary was first seen by us, we had reason for grave concern. At 5½ 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 tenuous 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. At one point in the testing, an unexpected sound (the Bayley test bell) shattered her threshold of tolerance, and she collapsed in terror.

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 Mary 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. Mary and her mother, Mrs. Adelson, and Mrs. Evelyn Atreya, as tester, were present.

Mary 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 Mary 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 psychologists. Mrs. Adelson maintains composure and 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 *hear* her baby's cries!" This led us to the key diagnostic question: *"Why doesn't the mother hear her baby's cries?"*

The Mother's Story

Mrs. March was herself an abandoned child. Her mother suffered a postpartum psychosis shortly after the birth of Mrs. March and her twin brother. In an attempted suicide, she had shattered part of her face with a gun 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 Mary was not her father's child. Mrs. March had had a brief affair with another man. Her guilt over the affair, her doubts about Mary'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 Mary," she thought. "They stared at her and knew that her father was not her father. They knew that her mother had stained her life."

Mr. March, who began to appear to us as the stronger parent, was not obsessed with Mary's paternity. He was convinced that he was Mary's father. And anyway, he loved Mary 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 Mary!"

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 possible crimes of the imagination. On several occasions in reading the clinical reports, we had the strong impression that Mary 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 Mary 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 Program 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 grunts 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