Four Decades in Infant Mental Health

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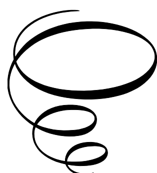
This Hallowed Ground

By

Michael Trout

Cambridge Scholars Publishing



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…for Mary

In Memoriam

Martin Buber (1878-1965), Austrian philosopher and author, captured my imagination when I was still a boy. It is to him that I owe whatever devotion to "hallowing the everyday" I tried to demonstrate in my work during those decades of practice, and that I mean to reflect in the stories you will find herein. It is to this man I owe the principles that formed the core of psychotherapy as I knew it: relatedness, and newness.

> *In spite of all similarities, every living situation has, like a newborn child, a new face, that has never been before and will never come again. It demands of you a reaction that cannot be prepared beforehand. It demands nothing of what is past. It demands presence, responsibility; it demands you*
> —Buber, Martin., 2003. *Between man and man*. London: Routledge Publishing, 135.

TABLE OF CONTENTS

Acknowledgements ix

Prologue xi

Chapter I 1
The Invitation

Chapter II 10
Waiting for the Shoe to Drop

Chapter III 19
On Transference

Chapter IV 28
Depression in a Warrior Father

Chapter V 48
Abusing Babies

Chapter VI 57
An Adoption Story

Chapter VII 65
The Anniversary Thing

Chapter VIII 74
The Foster Mom Who Knew Just What to Do

Chapter IX 79
"There's the Baby. Do You Want Him?"

Chapter X 89
The Professor and the Toddler in the Doorway

Chapter XI 98
The Startling Power of an Early Narrative

Chapter XII 109
When We Fail

Chapter XIII 118
The Little Girl Who Remembered the Fire

Chapter XIV 127
How Parents Figure Out What Happened to *Themselves*

Chapter XV 137
The Body Remembers

Chapter XVI 148
Can Internal Working Models Begin in Prenatal Life?

Chapter XVII 157
The Search for Coherence

Chapter XVIII 167
Who We Are

Chapter XIX 177
The Calamitous Results of Stirring Together Intergenerationally-Transmitted Pathology, Therapist Arrogance, and Clumsy Casework

Chapter XX 192
They're Practically Twins

Epilogue 198
A Little Archeology

About the Author 213

Subject/Author Index 215

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The incalculable help afforded to me, over the years, has made it clear: self-sufficiency is not all it's cracked up to be. These four decades of work, and the book that reports on it, would simply not have happened without a number of remarkable people who stepped into my life, my brain and my heart. I often didn't know why they were there, at the moment. Now I do. They made my professional life extraordinary, with endless acts of teaching, support, and—sometimes—love.

Betty Tableman had the vision to put together the first clinical training in infant mental health in the world, making a deal with the most brilliant mentors in the work extant, in Selma Fraiberg and Edna Adelson. She is a hero, if not a grandmother, to many in the field, and I am among them.

Selma Fraiberg could feel inaccessible. It was torturously difficult, for many of us, to integrate how such brilliance and such empathy could co-exist with aloofness. But to this day, I remember every detail of the phone call in 1981 from her longtime secretary, announcing her death. If I could, even once, mirror her astonishingly-compelling way of *being with* a family, and then describing that family, I would consider my life well-lived.

Bill Schafer taught me the true meaning of reflective supervision, which meant some serious knuckling-down about translating theory to practice. Rarely have I been as intellectually stimulated (and challenged) as I was in those hours with him in the basement of the Project.

Lisle Earle opened the door to a once-in-a-lifetime chance to train in what must have seemed a bizarre developmental and clinical theory, and Roger Vanderschie supported a service delivery system in the north woods of Michigan that must have seemed outrageous to the community mental health board to whom he was responsible.

Jack Stack invited me to join him in a private practice, allowing us to create something wondrous in Alma. He had been a beloved family physician in this small town for years, delivering thousands of babies and providing reproductive health services unavailable anywhere else in central and northern Michigan. He went back to pass his Boards in neurology and

psychiatry at the same time he was learning about Infant Mental Health, and we became friends and fellow travelers. (On those occasions for literal "travels", he always insisted on being the driver, arriving to pick me up having already stopped at a little shop downtown to secure standard trip food: cold Vernor's and warm cashews.) I miss him, as you can probably tell.

Edward Hinckley of Maine had a vision for the first six training films in the field, and offered financial support—on behalf of the State of Maine—for their production in the 1980's. He was my kind of man: gutty, bold, soft, and accessible. He taught me about life in the logging camps of Maine a century ago, and welcomed me into his home—a trek that sometimes involved leaving the car at the bottom of his mountain in Vienna, traveling the rest of the way up on a sled pulled by a snow machine. In my black topcoat—suitcase situated precariously on my lap—I must have seemed as odd to him as his life seemed to me. It never mattered to either of us.

A small group of trusted colleagues sat with me over soup and bread in 2018 and 2019, studying the manuscript for this book. Usually in front of a good fire, they brought the intellectual fire of their own disciplines—clinical psychology, early childhood education, social work, nursing and counseling—to bear on their analyses of the chapters. It was a rare demonstration of colleagueship, for which I will always be grateful to John Jones, Joan Volkmann, Mary Koloroutis, Martin Srajek, Anne Clare, Delreen Schmidt-Lenz and Rebecca Molitor.

PROLOGUE

The impeded stream is the one that sings.
—Wendell Berry (Berry, W., 1983. *Standing by Words*. Berkeley: Counterpoint, p. 97)

Had you asked, I don't know whether I would have owned up to being a clumsy planner. Fifty years later, I admit that it does rather look that way. Or maybe I was just young.

When I was a boy, grandpa Trout would corner me at holiday gatherings with an annoying, dreaded, but well-intentioned solicitation of my Five-Year Plan. I always disappointed him.

Now I was sort of a grownup, standing in knee-deep snow in the middle of a Wyoming highway. I-80 was closed, owing to blizzard conditions, and a long line of stranded travelers were beginning to step out of their cars and into the cold, to talk with one another. A certain bond was felt, as we were truly in this predicament together, but the felt closeness increased exponentially when someone jumped out of a car with the news: Martin Luther King had just been shot. That's how I remember the date, and the time: 6:01 PM, April 4, 1968. It would be dark, soon (in more ways than one), as we awaited buses and state police escorts to transport us to overnight accommodations in a dorm at the University of Wyoming.

Some things, at least, looked brighter the next morning. Granny had told me it usually worked that way. The freeway reopened, and travel was unimpeded until Nebraska, when my trusted-but-tired Volvo gave up the ghost in the middle of the night, outside the village of Kearney. The next day, the fellow who swept up around the garage where my heap had been hauled recollected that he had a motor from a weird Swedish car just about like mine, in his shed at home. That motor was fetched, looked over, installed and I was on my way within hours. Day did, indeed, follow night. Once again.

I was on my way from Divinity School in San Francisco. Having relinquished my 4-D deferment at the height of the Vietnam War (that planning problem again, you might say), I had applied for status as a conscientious objector, and was now ordered to a 6,000-patient mental hospital for two years of

service. Most assuredly, I was unaware that the stage was going to be set for a four-decade-long career in infant mental health. But first I needed to spend a few years working with chronic mental patients in a then-121-year-old asylum on the plains of central Illinois.

King was dead. For no reason whatsoever except hate. Was I really being asked to give a go at restoration of "mental health" to folks unlucky enough to have stepped out of line once upon a time and gotten themselves locked up for 30 or 40 or 50 years in a state-run asylum? Or was I being set up to eventually ask the question that drives most of us who work with babies and their parents: What *happens* to people?

Two days after that halting on the freeway, where mourning for Dr. King commenced among a few hundred shivering travelers standing on an interstate, a good deal of my home town in eastern Indiana blew up, killing 41 and injuring another 150. Fault lay, it was eventually discovered, with the unhappy mixing of multiple gas leaks around town, a large cache of gunpowder in a downtown sporting goods store, and a spark of never-to-be-discovered origin. For less accidental reasons, that same week Detroit began to burn, for the second year in a row, as folks tried to come to grips with the death of a leader we imagined could teach us, again, about love.

The next night I finally arrived at the gates of the mental hospital, only to find them locked (with all the patients inside, of course); the staff were on strike.

Things were, one might say, a bit unsettled.

Two months later, some of the other young staff and I were gathered in our newly-discovered hiding place on the abandoned fifth floor of the Main Building on the 53-acre campus of the mental hospital. This abandoned and dank repository of so many powerful moments and memories had been declared off-limits by the administration, of course, but someone had found the key—a clunky, gigantic thing—to the jailhouse door at the top of an endless spiral of metal stairs. Oddly, some of us liked to use the space for moments of respite. On a particular day in early June of that year, someone brought a tiny TV, found an outlet, and extended the rabbit ears so we could huddle around in stunned silence; Robert Kennedy had just been killed.

I don't even know if it was true that we were all in it together, in a place where nothing made sense. But it seemed that way. We were, really, no different from the 6,000 patients who surrounded us; none of us knew exactly what was real and what wasn't.

I think this is where I learned to *wonder* about things: the kind of wonder characterized by joyful inquiry, fueled by a driving curiosity, as if something were truly about to be discovered. I read hundreds of “medical” charts (oh, how we tried to pretend there was something scientific—or meaningful at all—about what we did in this place and wrote in those charts), struggling to make sense of the obvious question: How did these folks get here? Within months, it was evident that the diagnoses written in bold letters on the face sheets of these thick charts meant next to nothing. At best, they were nicknames (“the hebephrenic on Central”); at worst, they were condemnations to inescapable conditions.

We would sit in circles of 30 or more staff (the weekly events were, perhaps aptly, called “rounds”), with a single patient placed clumsily (let’s tell the truth: the real word is “humiliatingly”) in the center of the circle. We shot questions at the poor fellow (I was assigned only to male wards), whereupon we played “win-the-favor-of-the-psychiatrist” by guessing whatever diagnosis he had already decided was the right one. None of it had anything to do with clinical psychology, and certainly even less with anything developmental. It was boxing-up, pure and simple. And to justify doses of the phenothiazines that were so much in vogue. Once that was done, the patient was excused to go back to staring at the TV for a few more decades.

It would have been heresy to propose that we were as much the problem as we were the solution. (This axiom was widely understood, if rarely spoken: “If this patient hadn’t been crazy when he came here, he certainly would be after living here for a while.”) When four of us on the young staff signed ourselves into Chicago State Hospital for a short stay on a locked ward (one of the more creative and helpful parts of our training), we knew it for a fact: There was no requirement that the day-to-day behavior of mental patients would consistently match their “diagnosis”. We were on the inside during those few days, without keys, and that was all anyone needed to know to be sure of whatever brand of schizophrenia someone at admission said we suffered from.

And so I lost my faith in easy answers to tough, clinical questions. I didn’t, however, lose my faith in the questions. I found myself listening to the “rantings” of those who heard voices, carefully following their words while searching for meaning. I looked for hints about where these people had been and what they had seen. I lost whatever fear a reasonable person might think appropriate of what these reputedly “insane” people might do, of what might happen next. The lines between us dissolved. In all these ways, I was getting ready for Selma Fraiberg.

That happened (do you keep hoping for some sign of anything other than serendipity?) when I finished my term of alternative service, then doubled it, then followed my nose to geographic heaven: northern Michigan. The man with whom I was scheduled to interview was Director of a four-county community mental health system, in what I deemed one of the prettiest parts of the world. He was 30 minutes late. His beard was big enough to precede him into the room. He planted his work boots on top of the desk, and we proceeded to fall in love. This guy thought I knew enough to be trusted in a room with patients, but he also had another idea: He wanted to nominate me for a new, intensive training program in a field hardly anyone had heard of, with a magical and difficult lady in Ann Arbor. A Professor of Child Psychoanalysis, known at that time mostly for her work with blind babies, she had agreed to take six students from outside the university, as long as she could be assured they were "seasoned clinicians" (Oh, my! Did no one tell her about *me*?), and teach us about babies and mothers and development and a non-Buddhist view of *attachment.*

On to northern Michigan I went, then, and nothing would ever again be the same. I never once minded the 4-hour commute to Ann Arbor. Sitting in that library at the Child Development Project at the University of Michigan, looking at old reel-to-reel videotapes of families struggling to come to grips with their souls, their babies, and their pasts, I felt strangely at home. It made sense to me. A father playing a game with his blind infant son on one piece of video turned steadily but inexorably (one could almost see it coming) into an enraged daddy beating on his little boy's genitals. And I could "hear" the unspoken words of this awful "game"[1]: "But you will be impotent! If you can't *see*, you won't ever be a man. Don't you know how awful that will be? Don't you know how awful that has *been*, for me—to never feel good enough, to never feel like a man?"

I was a dope, in so many ways—undereducated, underexperienced, dumbfounded by what I saw, but unable to look away. My fellow trainees and I found that we could learn if we watched and listened ever so carefully. People would find ways to tell us about the most secret hurts, including ones they didn't even remember, themselves—until, that is, they had a baby. Sometimes they were able to be introspective, but more often—before anything as exotic as insight happened—they would starve the baby, or hide

[1] Prof. Fraiberg had just finished her brilliant paper, "The Clinical Dimensions of Baby Games", to be published just a year later (1974) in the *Journal of the American Academy of Child Psychiatry,* 13:202-220. It would not be the first time she taught us the magic of finding meaning in behavior.

her away under a blanket in the other room, or hit him, or leave her all alone. We would learn to sit with it all, asking gentle questions, *being with,* managing our own panic, managing our own need to *fix*, managing our own need to be brilliant, managing our own emerging infancies.

I was only supposed to be an observer with the very first family assigned to me, and I drove deep into the woods of northern Michigan to do no more than that. Not having read the Rule Book, however, the mom dove in, announcing how different her identical twins were, one from the other, and always had been. Her evidence was clear: after their premature birth, she went to them, she said, viewing them in the nursery before the helicopter arrived that would whisk them off to the regional NICU. That's when it all began, she averred. Two-pound Timmy looked at her and smiled, while Tommy "refused to even look at me".

When the boys were discharged 90 days later, she turned the care of one of her new sons over to her mother, 35 miles away. She kept the other. There was no doubt in my mind about which child went where.

I wanted to show my supervisor my "observation" family. Was I making this all up? Was I seeing the profound discernment—if not preference—I thought I was seeing? Somehow it surprised me that mom not only agreed to allow me to make a little film (the reels were only 3 minutes long, in those days), but she seemed positively eager—as if she wanted to make sure I was *seeing*. (Over the next 40 years, it would never cease to amaze me that the eagerness of families to tell their stories—even when they didn't know what they were—would overpower their presumed hunger for privacy.)

I rented an 8mm home movie camera from the local drugstore, and my foray into recording the nuances of infant-parent interaction began. Well, sort of. I left the lens cap on. Nothing

whatsoever was recorded that day. My own ambivalence about really *seeing* had overcome my common sense and my customary comfort with details.

A week later, we tried again. This time I brought along a colleague from the mental health center to actually hold the darned thing and assure there would be no further impediments (unconscious or otherwise) to making a perfectly innocuous 3-minute film. My first.

It would not be my last, as it turned out. Over the next four decades, I would treasure these tiny bits of data—acquired in hundreds of living rooms and offices—about what goes on in families. I would teach others using these

very private peeks into the souls of mothers and fathers and babies, and we almost always made brand-new observations together at every viewing.

That first one would not be "perfectly innocuous", either. In those 180 seconds, mom managed to orchestrate—with not the slightest conscious intent, of course—a little cleanup scene in which the depth of her estrangement from Tommy would be so evident that even she would gasp upon watching it with me, in the next session.

No longer was this my "observation case". They needed help. I had no idea where to begin. Which is, of course, the very best way to begin.

So for the next 41 years, I saw patients of all ages, representing a broad socioeconomic and educational spectrum, living in shacks at the end of two-tracks in the woods of northern Michigan and in elegant suburban homes surrounding a world-class university in Illinois. They came for all sorts of reasons, as you would expect, but this they had in common: they came to work, even when they were clumsy at it, and even when it took a while for us to figure out what we were working on.

The psychoanalytic theory that underlay the work seemed mysteriously common-sense to me. And once I began walking into homes—where I saw first-hand all the trans-generational action of repetition and struggle-not-to-repeat and remembering-through-the baby—I found that psychoanalytic ideas explained things better than most.

I never quite figured it all out. I just kept watching, being curious, trying to follow my patients' stories. They never stopped being interesting to me. I never saw two patients who were alike. Ever.

I have often been asked whether the work was depressing or, at least, too-sad-for-words. After all, I watched moms beat their babies; I witnessed the agony of people in their worst moments; I had to stand by as some who seemed determined to destroy themselves nearly did so; and I watched children turn themselves inside out, fighting off the love they so very much wanted. It was sometimes my job to re-awaken pain in both children and adults who had developed a phobia for sadness.

But I never found it depressing. It seemed to me that I was usually in the presence of courageous people who were trying to understand why they loved—or failed to love—the way they did; why they kept marrying people who would abuse them; why they behaved in ways that were so obviously not in their best interests; why girl babies were so repugnant to them, or boy

babies so threatening, or vice-versa; why relationship after relationship ended at about the same anniversary, or in about the same way; why certain children—whose minds told them that attachment was dangerous—flailed away at it; why certain people, who had lost their capacity to detect *newness*, spent so much energy perceiving all experiences as replications of old and awful ones.

Don't mistake: it wasn't all sweetness and light. Both the children and the grownups defended themselves. They resisted treatment, sometimes fiercely. But the babies—both the ones in the room, and the ones inside the moms and dads—kept speaking. After all was said and done, I was nearly always given the profound gift of being allowed to sit in their presence.

I'd like to tell you some of the stories of these remarkable people. I can't tell you so much about anyone that you might guess who they were; that would be disrespectful. But I can tell you a little bit about several of them—just enough that you can, maybe, share in my fascination about how we humans do our work of survival and adaptation and transformation.

If you're such a careful and mindful reader that you manage to detect a clinical method, I hope you'll have a grand time sharing your thoughts with someone who will arm-wrestle you about it. After all, emergence of a theory of practice should always be bumpy, never easy. We should avoid strategy like the plague. The seduction of formulaic approaches is just as strong as the seduction of the creation and use of boxes—no matter how carefully-crafted—in which to insert people.

So be cautious if you think you detect repeatable strategy herein. You probably don't. Few things work twice in a row. Our task in application of the principles of infant mental health is clear, but not because it can easily be reduced to matching therapeutic behaviors to diagnostic categories. Instead, we are permitted to look closely and to wonder. We are required to attune to the affects, the defenses, the coping strategies, the *persons* we are looking at and wondering with. And we have a chance to *hold*.

If you find yourself unable to forget some of the people whose stories I tell in these chapters—astounded at their persistence, surprised at how they turn attention to the biggest secrets and greatest challenges of their lives—welcome to the world of infant mental health. You might find yourself in love.

***

Study/Discussion Questions:

1. How has your professional life evolved differently than you expected?

2. When do you recall first becoming obsessed with curiosity about the question: What *happens* to people?

3. When—if ever—did you start to doubt the wisdom of diagnoses—or even of diagnosing?

4. When were you first overcome with the joy of *wonder,* as a thing in itself?

5. Did you also find yourself having no idea how to begin? What did you do in response? Did you ever have the impulse that this might be the very *best* way to begin?

CHAPTER I

THE INVITATION

I have never stopped pondering how variable and courageous rituals of entry in infant mental health often are.
—Michael Trout

Some of us entered the special world of infant mental health from adult or pediatric practice, where most things—including the invitation to be involved, in the first place—were reasonably clear. In that world, a referral was made and it usually included something approaching a directive, or a statement of the problem. Or perhaps it was the patient who was calling, so we could hear, first-hand, a complaint, or a need, or a hope. In nearly all these instances, *somebody* was asking for our help. In this world, rarely did we encounter an angry person standing on the front porch with a broom (or worse) in hand, blocking access to all that was within. People even sort of acted as if they liked us, and maybe even welcomed us.

We were invited.

In infant mental health, by contrast, we more or less stumble in the door, as often as not. We set about to learn, on the job, what it's all about. If a referral has been made by someone other than the parent, the parent is often not too happy about it. We encounter utter denial of the very existence of a problem. Most of us in this remarkable, specialized practice can tell stories of being threatened, but that's only one of the many ways people find to let us know that this whole thing is not going to be easy. We rarely start out with a shared understanding about why we're there, and there's nearly always anxiety (on everybody's part) about what we're going to do.

We have to *discern* an invitation.

Indeed, we often have to wait for it, to imagine it, to look for it between lines of defense that may include sullenness, or even rage. While we wait, we keep coming, keep being present, keep wondering, keep noticing. More often than not, we discover an invitation to enter. We find out why we're there. We may even find the "it".

It was a child welfare worker who asked me to meet Becky, a pregnant high school girl living in a home for unwed mothers 100 miles away from her parents. She was to be released in a few days, and had decided to keep her newborn son, Jeremy.

While Becky's pregnancy was described in the referral papers as "uncomplicated", and the delivery as "unremarkable", I soon learned that neither was actually the case. Her pregnancy was, in fact, marked by increasing resentment of the problem bump in her belly. She found herself able to think only of female baby names, and slowly realized that she very much detested the thought of delivering a male child. She began to consider abortion. Discovering it was too late, she wondered if a coat hanger would hurt too much.

Things had started going south for Becky some months before she became pregnant, right after a family visit to grandma's house in North Carolina. Immediately following the return home from this visit, Becky reportedly became "uncontrollable". Communication between her and her parents deteriorated nearly overnight. No one seemed able to explain the connection between these changes and the visit to North Carolina; later I would learn that no one had even thought about it. When I asked, everyone seemed perplexed about the meaning of grandma's house. The suddenly-emerging pattern of drug use, school truancy, depression and running away from home were certainly noticed and considered problematic, but were attributed to rebelliousness or some other, vaguely-defined mental health problem.

In the middle of this strange and newly-emerging chaos, Becky had become pregnant by a boy for whom she cared rather little. He was uninvolved in the pregnancy, in spite of Becky's repeated efforts to draw him in. She pleaded with him to care, and to stay; he rejected her and, during one encounter, beat her. She was undeterred in her yearning, but also unsuccessful in winning his interest in either her or the baby. She was sent to the home for unwed mothers where, it was hoped, she would conclude that relinquishing her baby would be best.

On the delivery table Becky found herself looking at her newborn's penis before she looked at his face, musing on the near-certainty that her one-minute-old son would soon leave her, as males always had.

Back in her room, Becky decided not to breastfeed, after all.

Becky and newborn Jeremy were released together from the unwed mother's home. As I awaited her arrival for our first appointment—at my office, because Becky said she wanted privacy that would not be afforded at her parent's house—I imagined a detached mother and an angry, defiant teenager. I found, instead, a gentle child cuddling her newborn. Jeremy had some swelling in his left eye (a byproduct of Becky's sexually transmitted disease) and doctors were concerned about blindness. He was, otherwise, healthy. Becky handled her son with tenderness, and there was an easy rhythm and mutuality in their interactions.

Soon I would learn that a young girl in a reportedly disorganized state could actually be working on a revision of history. I was to be let in on the story. I was to be invited to see, if not to intervene.

In a subsequent session, Becky was clearly anxious and Jeremy was responding predictably: he was fussing. The agitation escalated as the session wore on, and Becky had no answers to my quiet questions about what might be happening, and about what each of them needed. It did not dawn on me that the lesson for today required that I participate, but not merely with my questions and interpretations. Becky wanted me to *take* Jeremy, at least for the moment, and she emphasized the point by insisting that she could not quiet him. She asserted that he could not be allowed to continue fussing; the doctor had warned her that Jeremy might burst a blood vessel in his eye if he were allowed to cry too hard, or for too long. Reluctantly–ever alert to the possibility of offering the wrong kind of help and inadvertently adding to Becky's sense of helplessness–I accepted her son into my arms.

He relaxed almost immediately. With the room newly calm, and her son situated in the arms of her bewildered male therapist, Becky launched into an angry monologue about the treatment she had received, for much of her life, at the hands of men. She spoke of betrayal by her boyfriend, Jeremy's father. She talked about the several boys she had been with before Jeremy's father–none of whom, it turned out, had proclivities toward loyalty and gentleness.

Then she mentioned that the man whom I had understood to be her father was actually her stepfather. Her birth father, it turned out, had been a military man on a base in North Carolina, near the little town where Becky's mother grew up, and where Becky's grandmother still lived. He got Becky's mother–a "townie"–pregnant, but showed little interest in her, or in the new baby girl. Within a few months, he was transferred to Germany. Becky's

first memory of him was when she was five years old; she never saw him again, after that day. When Becky was seven, her mother married Becky's stepfather, whom Becky persisted in resenting.

Over the ensuing months of this clumsy intervention, Becky demonstrated that she could be a thoughtful and caring mother. She spoke openly, however, about how hard it was to feel attached to her son. She continued to yearn for Jeremy's father, even while acknowledging what a poor choice he was as either a dad or a mate. She began to look at Jeremy less. She left him on the floor, crying, during one session, as I struggled pathetically to interest her in his pleadings. She began to have trouble sleeping, and she complained of a pain in her abdomen. She began to "forget" appointments with me. And then I learned that Jeremy's father had married another local girl (whom he had also impregnated).

Becky began to take note of how quickly Jeremy was becoming a little boy. By the age of three months he was, to her, no longer a baby. She began to stay out late, leaving Jeremy with her parents. Notices from school indicated that she was beginning to fail her classes. And she began to hold Jeremy with detachment, on the end of her knee, facing away.

Increasingly, Becky failed to show up for appointments, but would call me about seemingly innocuous matters during the week. I asked for a session that would include Becky's parents, but that session only made clear that a code of silence was being enforced about whatever it was that was causing things to fall apart. This session did serve to drive home one point about how the family operated: Jeremy was being transferred, slowly but steadily, from his mother to his grandmother, for his primary care. Perhaps I should have understood that Becky was preparing to leave.

Our last session together happened at a coffee shop–a compromise to which I agreed, after so many missed appointments, in the hope of reconnecting with this mother, who was steadily slipping away. Becky acknowledged that she was growing "cold" toward Jeremy, who showed signs of his increasing discomfort with his mother by stiffening in her arms, and refusing her half-hearted efforts to console him. Becky said she was actually beginning to feel "cold" toward everyone in her life, and added that it had been a long while since she cried about anything. She acknowledged that she had recently gone downstate with a couple of girlfriends to visit some boys. She had intercourse with one of the boys and was terrified that she might be pregnant again.

Sitting in the coffee shop with me, she put Jeremy on the floor. She wanted to show me what it was all about: he was beginning to crawl. *Away*, she insisted. It was the sight of his moving away from her that had turned her "cold" toward him (and everyone else). He was *leaving her*, as boys always had. She was quite certain that he would, as a five-year-old (referencing, coincidentally, her age when she remembered seeing her birth father for the first and last time), reject her completely. She would leave him, first.

When Jeremy was ten months old, Becky left home and moved in with girlfriends, nearby. She did not take her son, and rarely stopped in to see him. Within weeks, she moved to another part of the state to live with another girlfriend. She called me from time to time to let me know that she was working in a restaurant; that she was being sexually active with several boys in her new town, but she was not pregnant again; and that she missed Jeremy terribly and was looking forward to having enough money to send for him. After a few weeks, however, she began to acknowledge that she would not be sending for Jeremy; it would be, she thought, too difficult for him to now leave her mom and stepdad, the people who had become his parents. When he was a year old, she returned to our town to appear in court, approving of Jeremy's adoption by her parents.

I had misunderstood what the original "invitation" meant, and what the mission was. I had presumed I was there to support the growth of attachment between Becky and her little boy. In that mission, I had certainly failed. There was another reason for me to be there; so far, I had failed to understand what it was.

And then the most peculiar series of events began to unfold. Her phone calls revealed that she had met a young man who was about to enter the armed forces, and she was pregnant by him. He would go to basic training, soon. He would be stationed at a base in North Carolina–as a matter of fact, at the one where her father had been stationed, 17 years before. She moved back in with her mom and stepdad; there would, after all, be no place for an unmarried, pregnant girlfriend on the base.

She made no pretense at functioning as Jeremy's mother while living in the house with him. She cried about this, on occasion; at other times she raged at her parents for taking him away from her. She took note that her stepfather seemed to be home much more, and was more involved in family life, since Jeremy became "theirs". She thought it was "cool" that Jeremy had brought her parents together; it almost seemed, she mused, that her mother was getting a chance to "try it again": to raise a little one, this time with a father

really there. She then shifted to speaking romantically about her young man, and the baby inside her, and their imminent reunion.

Word came, following basic training, that Becky's boyfriend would be sent to Europe–to Germany, actually. Becky was upset, but didn't seem to recall, consciously, that her own father apparently effected his escape from fatherhood by way of an assignment in Germany. But she did make a decision: she would move in with her grandmother in North Carolina, in the very home to which she had been brought as a newborn. She would be near the base, and she would stop the transfer. She was on a mission.

Weeks passed before I heard from Becky again, and the message came in letter form. She was jubilant. She had gone to the base commander, and he had agreed it was important that a father not be separated from his pregnant girlfriend and new baby. He modified his orders. The father of Becky's second baby would remain on the base in North Carolina until everything settled down, and the two of them could be married. She would then be in a position to accompany him on his assignment.

One paragraph particularly jumped out at me. She offered the news that her new baby was going to be a girl, adding, "I know you'll understand what that means, that this one is a girl. She will have her father." I never heard from her again.

Do we ever get used to such complicated invitations, such muddled mission statements, such inconclusive conclusions? Years after I knew Becky and Jeremy, they came back to my mind as I was learning from Maori colleagues in New Zealand about native traditions regarding invitation. They take great care with the important event of entry into one another's village—and, in my mind, to the event of entering into another's heart. It's never taken for granted. Indeed, in one part of the tradition, a welcome ceremony of sorts happens before entry, when a visitor stands at the gate, where she emits a particular cry. She is asking permission to come in. From within comes a *karanga* (which sounds very much like a high-pitched screech to these Western ears). It's a song of invitation. Sometimes the visitor responds to the song of invitation with her own call of acceptance. Only then does the visitor move inside.

Why do tears come to my eyes as I tell you about it? I heard these calls during my visit to the country of the Maori, and I trembled in response to the incredible symbolism: taking time to notice that we are about to enter a

place where we are a guest, to ask permission, and then to acknowledge receipt of the invitation to enter.

In my many years of practice, did I ever discover a ritual for entry? Did I ever learn just how to ask permission: not only to enter the room, but to sit at the table, to be surrounded by the intimate physical details of a patient's life, and to begin asking the most astoundingly intimate questions about the core events, hurts, tragedies, and joys that came before? Did I honor the space I was entering? Did I acknowledge that I was about to watch interactions between baby and parent that were not only personal, but would inevitably be revealing?

When the elder sings the *karanga*, presumably everybody knows the terms of the invitation, and there is little doubt about what is going to happen next. It sounds so wonderfully clear. Maybe my longing for such clarity is why I cried when I watched it that day in New Zealand.

I maintain, however, that what Becky (joined by her family, perhaps?) did was no less noble. This little girl figured out a way to change history: to give her mom a second chance (to raise a baby with a father nearby), and to get herself a baby girl whose father she could retain. A little girl would get her long-lost daddy back. And she would find a man who understood these things to witness it all. She invited me.

After all these years, these dynamics—muddy and frustrating as they sometimes are—never cease to amaze me. And I have never stopped pondering how variable and courageous rituals of entry in infant mental health often are.

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Study/Discussion Questions

1. Do you agree, or disagree, that an invitation is often there, even when unspoken, and maybe even unacknowledged by the party making it? Does this just sound like a made-up justification for getting people into therapy?

2. What approach would you have taken with Becky: an unruly, sexually-active, rebellious adolescent mom who seemed to be pulling away from responsibility, and pulling away from attachment with her little boy?

3. What do you think about how things worked out with Becky and Jeremy?

4. Why did Becky declare, in her final letter, that I would understand the meaning of her next baby being a girl?

5. In the culture you represent, are there rituals for entry? Are there ways of issuing an invitation to enter a private domain?

6. Can you imagine a ritual or tradition for a clinician asking permission to enter the private space of a patient? Have you ever observed it? If so what was the effect?

Pull Quotes

Rarely did any of this process of getting started involve an angry person standing on a porch with a broom (or worse) in hand, blocking access to all that was within.

We have to discern *an invitation.*

On the delivery table Becky found herself looking at her newborn's penis before she looked at his face, musing on the near-certainty that her one-minute-old son would—as males always had—soon leave her.

Soon I would learn that a young girl in a reportedly disorganized state could actually be working on a revision of history. I was to be let in on the story. I was to be invited to see, if not to intervene.

Over the ensuing months of this clumsy intervention, Becky demonstrated that she could be a thoughtful and caring mother.

Jeremy was being transferred, slowly but steadily, from his mother to his grandmother, for his primary care. Perhaps I should have understood that Becky was preparing to leave.

She wanted to show me what it was all about: he was beginning to crawl. Away*, she insisted.*

I had presumed I was there to support the growth of attachment between Becky and her little boy. In that mission, I had certainly failed.

…it almost seemed, she mused, that her mother was getting a chance to "try it again": to raise a little one, this time with a father really there.

She offered the news that her new baby was going to be a girl, adding, "I know you'll understand what that means, that this one is a girl. She will have her father." I never heard from her again.

I trembled in response to the incredible symbolism: taking time to notice that we are about to enter a place where we are a guest, to ask permission, and then to acknowledge receipt of the invitation to enter.

A little girl would get her long-lost daddy back.

CHAPTER II

WAITING FOR THE SHOE TO DROP

It may be that when we no longer know what to do
we have come to our real work,
And that when we no longer know which way to go
we have come to our real journey.
—Wendell Berry (Berry, W., 1983. *Standing by Words*. Berkeley: Counterpoint, p. 97.)

The timing of things—how and when we get to learn why we're *really* there, for example—rarely seems to be in our hands. Perhaps that's as it should be. Trying to squeeze-fit a formulaic strategy of intervention on top of the unique complexity of each family can be a bit of a problem. It's just one of the many reasons why structured and manualized treatment "programs" often fail to get to the "heart of things" (in more ways than one), in infant mental health.

For example, does it not seem reasonable that a patient would need to spend significant time figuring out if we're *qualified*, if we might be *the right one*, if we might be *the one who speaks their tongue?* I certainly understand the appeal of interventions that are less dependent on the actual connection between therapist and patient. It makes administrative sense that offering services that are standardized, evidence-based, and repeatable would make life far more predictable and comfortable for all—perhaps even for the families, themselves, who are then excused from getting to the heart of things. Many families, after all, may be perfectly relieved (at least at one level) with a diagnosis and a superficial stab at intervention, even when the diagnosis is incorrect (or unhelpful, or off-the-mark) and the intervention doesn't work.

One middle-aged woman for example, couldn't remember why she even made the appointment, so she couldn't actually say why she was standing there, in my waiting room. Nothing was actually "bothering" her. Her two daughters were nearly grown, she was successful in her work, she had a loving marriage, and she was close to her extended family. She was great at coping, she explained. Based on having heard one of my lectures, she

concluded that I might be almost as smart as she, and that seemed to tickle her. So maybe she would “just run a few things” by me. Over the next few weeks she seemed to fumble about, as if looking for something but not remembering what it was, exactly.

But then the most unexpected thing happened: she became pregnant. It was most assuredly not planned, she reported. She was beside herself. Her customary sure-footed, confident Self seemed to disappear, replaced by a fretful, angry, child-like figure who appeared to be sitting in the middle of a road, waiting to be run over by a truck of uncertain origins and uncertain dimensions, with unclear lettering on the side.

The baby inside was in danger, she said. No, she wouldn’t hurt it, nor would her husband. But the baby was definitely in danger.

So was she, she hinted. She would have to be *looked at* by doctors and others who were supposed to be caring for her, but who might do bad things while looking and caring. And she would be put in positions in which her control would be reduced: she would be medicated, perhaps; she might be asked to spread her legs apart for examining residents; things might be shoved down her throat.

A healthy daughter was born, at full term. Mom began to have horrible dreams about harming the baby. She rushed her to the emergency room one night because she had stopped breathing. Except she hadn’t. The physician on call—who knew mom professionally—asked her what was really wrong, since the baby was fine, and he was sure mom must know it. This was only the first of several panic-driven trips to the hospital, each characterized by a terrified mom declaring that her baby was choking and couldn’t breathe. No choking was ever observed by anyone else, and no breathing problem was ever discovered.

Out of the blue (It often seems so, doesn’t it? It never is.) mom sent me this poetic email one night:

> *If there is no voice*
> *no sight*
> *no sound*
> *no way to*
> *move the hands*
> *does that mean*
> *there is nothing*
> *important to be said?*

I didn't understand, until I got to the final line of this late-night email: "So here is a thought, Michael. If I have to translate an event to you where I couldn't see, hear, speak, or move—what language do I use? How will you understand?"

And then the zinger: "Do you speak that language?"

There it was. For the first time, I began to have a hint about why this mom had chosen me. She had a story to tell. Evidently it was a story about which she had little concrete memory, and she was looking for someone—maybe a person who knew about babies—whom she imagined might *get* it. All this time (when I had felt so useless, unable to find a way to help, unable to even discern what the *topic* was) she had been testing her sense that I might know this language about baby's experiences, and about memory that is made up mostly of sensation. Perhaps I might know the language of babies.

I would learn that she had come to me seeking help for a baby that didn't even exist, at the time, but which she somehow knew was coming. Without help, the baby might be hurt. It would have to do with choking on something that would be put in her mouth, or down her throat. Mom was determined to keep that from happening to her baby. I came to know that she had had no such helper, when she was a baby, when someone was putting something in her throat that didn't belong there.

Quiet patience is required while the patient looks us over, so to speak—measuring us according to parameters that are quite unconscious. Once we pass muster, then we wait patiently for the shoe to drop—for some hint at what the problem really is. It becomes part of our responsibility to remain in a state of *wonder*, carefully *following* what we see, holding back our brilliant conclusions, lest we get ourselves in the way of things. Then, and only then, do we get a peek at what the problem might really be.

I shudder to think how miserably I would have missed the point had I taken another family's initial presentation of a presumed vision problem only at face value. When their baby did just fine with vision tests, and no other disability could be found, would they just be sent on their way?

How could I have known that a "vision problem" had to do with adoption and adoption reversal?

These well-educated, energetic, thoughtful parents had experienced years of struggle with infertility before adopting a little boy, now ten months old. They said that everything was wonderful with this child except for one