MELLANRUMMET
NORDISK TIDSKRIFT FÖR BARN- OCH UNGDOMSPSYKOTERAPI
NORDIC JOURNAL OF CHILD AND ADOLESCENT PSYCHOTHERAPY

Lena Schestag,
Janina Mehner-Gentner,
Korinna Fritzemeyer
Berlin

Early effects of *ghosts in the nursery*

Pathological defences of an infant born in exile

Looking at human history, including the horrifying war unfolding in Ukraine, it is a bitter truth, that war and violent conflicts are inextricably linked to mankind. They force people to leave their homes and seek refuge in a different place, where they hope to feel safe again and to build a future for themselves and their families.

Just one week after Russia attacked Ukraine, one of the authors went to visit one of the mother-child groups of the early prevention project "Strong together!". As outlined below in greater detail, "Strong together!" is a prevention project for refugee families, which aims to support the early relationship between mothers who fled from war-torn countries and their children born in exile. During the group session, a mother who fled from war in a Middle Eastern country, asked herself and us, whether it is still safe to stay in Germany or whether she and her family should resettle to yet another country. Her question made us realize how ready and prepared she is to move again – with memories and fears of war and flight present just below the surface. It showed us how fragile her inner sense of safety is, and how easily it can be affected by the outside reality. Also, it made us worry about possible effects of this trauma-induced hyperexcitability on her children.

One of the first psychoanalysts to observe and study the impact of parents' distress on their infants were Fraiberg and her colleagues from the Infant Mental Health Program in the 1970s (Fraiberg, 1980/2011). The program was developed to support parents who have had traumatic experiences in their childhood and who were therefore unable to adequately care for their infants. Fraiberg and

colleagues described this phenomenon as "ghosts which appear in the nursery": Repetitions of the parents' past experiences in present interactions with their infant (Fraiberg, Adelson, & Shapiro, 1975; Fraiberg, 1980/2011). Since then, the negative impact of parental childhood trauma on the parent-child relationship has been repeatedly investigated in empirical studies (e.g. Lambert, Holzer & Hasbun, 2014; MacMillan et al., 2021; Murphy et al., 2014). In this field emotional availability, measured with the Emotional Availability Scales (EA Scales), proved to be a valuable construct for understanding and assessing caregiver-child emotional relationships (Biringen et al., 2014).

The prevention project "Strong together!" for refugee families primarily focuses on parental burdens and potential traumatization caused by war, persecution, flight and forced migration, as well as post-migration stressors and their possible adverse effects on parenting skills. However, becoming and being a parent naturally resurfaces a parent's own childhood experiences. These can be particularly difficult to process when disconnected from a home country and family members (Leuzinger-Bohleber & Fritzemeyer, 2016). For this reason, the project also encourages mourning processes by supporting the parents in actively recalling their childhood experiences and memories. The ghosts, which appear in the nursery in exile in our project not only stem from the parents' childhood but also from more recent traumatic events. As we know from trauma research this can also activate adverse childhood memories, inhibiting healthy processing of recent trauma (for example Derluyn, van Ee & Vindevogel, 2019; Negele, Kaufhold & Leuzinger-Bohleber, 2016; Ozer, Best, Lipsey & Weiss, 2003).

Fraiberg (1982/2003) not only observed parents' past experiences being repeated in interactions with their children but also infants readily adapting at a very early stage and learning how to protect themselves from their parents' trauma-induced behaviour. This paper aims to explore whether Fraiberg's concept of early pathological defences can serve as a meaningful approach to identifying and exploring early disruptions in the single case description of a mother-child dyad from the early prevention project "Strong Together!". The psychoanalytic perspective on the case will be associated with emotional availability (measured with the Emotional Availability Scales, Biringen, 2008), a widely used construct, which "…refers to the capacity of a dyad to share an emotionally healthy relationship (Biringen et al., 2014, p.114)". The latter is based on attachment and emotional psychological theories. Using different theoretical perspectives in the sense of theory triangulation (see Flick, 2004; 2010) holds the potential for a more comprehensive, possibly more detailed gain of knowledge. In doing so, the goal is not to achieve more valid or objective results. A single case design inherits some limitations, which are discussed in the last section. It can nevertheless be an important starting point and an appropriate method, especially when approaching a highly complex field of study like transgenerational transmission of parental trauma in the context of war, flight and parenting in exile (see Rustin, 2019). Furthermore, we want to reflect upon the conjunctions of Fraiberg's psychoanalytic perspective and the construct of emotional availability, measured with the EA Scales.

In this paper, we will first present a brief project outline of "Strong together!" and some further thoughts on trauma transmission, early pathological defences and emotional availability. Second, we will attempt to understand the clinical material – a video recording, some background information and impressions from the practicians – through the lens of Fraiberg's concept. Findings will be linked to ratings of the videotaped mother-child interaction using the Emotional Availability Scales of the same case (Biringen, 2008). Lastly, some hypotheses will be generated as to how the maternal experiences of war, relocation to a foreign country and related stress might affect the dyadic interaction observed, thus the child.

"Strong together!" – an early prevention project for refugee families

"Strong together!" is an early prevention project for children (0 to 4 yrs.) and their parents, who fled from war and crisis zones, predominantly from the Middle East. The participating mothers and children are invited to professionally led, weekly mother-child groups on the premises of a large hospital in Germany. Until recently, these meetings have been taking place online due to the pandemic. The professionalization of the group

leaders, who are psychologists, child nurses or pedagogues, takes place within weekly group supervision provided by a psychoanalytic professional. "Strong together!" is a follow-up project of FIRST STEPS (ERSTE SCHRITTE), implemented by the Sigmund-Freund-Institute in Frankfurt/M., Germany (for more information about the concept and implementation of FIRST STEPS, please see Leuzinger-Bohleber & Lebiger-Vogel, 2016). Both projects are developed using the principles of psychoanalytical and attachment theory. They are also based on the knowledge that migration and flight are often associated with traumatic experiences such as combat, insecure living situations, and the loss of relatives and friends (Schestag et al., 2021; Schouler-Ocak & Kurmeyer, 2017). These experiences can cause multiple burdens which not only affect those who experienced it themselves, but also subsequent generations (Danieli, 1998; Grubrich-Simitis, 1979; Fritzemeyer et al., 2019; Moré, 2013; Parens, 2001). The project "Strong together!" provides preventive support for the early childhood experiences of children with their migrated and fled mothers as well as supporting integration and the empowerment of participating mothers. In weekly group meetings, mothers can experience a holding environment (Winnicott, 1973/2015), where stressful experiences from the past and present can be shared. In cases of severe trauma, further interventions have been developed and the affected person was referred and accompanied to appropriate services. These include treatment centres for traumatized refugees offering counselling and psychotherapy, individual caseworkers, and women's and children's shelters. In summary, the aim of "Strong together!" is to mitigate the risk of passing on a mother's traumatization or acute stress reaction to the next generation, thereby promoting healthy early development of children born in exile. Because refugee families are not only considered difficult to reach by standard early prevention offerings but also high at risk to experience psychosocial distress (Eickhorst et al., 2016), a formative evaluation of "Strong together!" was conducted in 2019. The goal was to examine who could be reached with the project, what participants had experienced and how the project could best adapt its offerings to the needs of the participating families (see Schestag et al., 2021 for further information). Understanding the trauma history of participating mothers is extremely challenging for the group leaders, but it is a core element of supporting mothers and planning psychoanalytically informed interventions.

Thoughts on transgenerational transmission of trauma, early pathological defences and emotional availability

There is a consensus in research and practice that war, persecution, flight and forced migration often come hand in hand with traumatic experiences, which can cause multiple, lifelong burdens on those affected and subsequent generations (Bohleber, 2012; Danieli, 1998; Kogan, 2012; Leuzinger-Bohleber & Fritzemeyer, 2016; Moré, 2013; Volkan, 2001). Although there is a rich and growing body of literature investigating the mechanisms, dynamics and pathways of transgenerational transmission of trauma caused by war and violent conflicts, this topic cannot be exhausted due to its ever-changing nature. Every war or conflict takes place in a different social, cultural and political context, so each situation needs to be independently considered when trying to understand the trauma and its consequences on those affected (Becker, 2006; Bohleber, 2000; Leuzinger-Bohleber & Fritzemeyer, 2016; Zimmermann, 2012). It is necessary to draw on the research that has investigated the impacts of trauma from past wars and conflicts while keeping in mind the changing outer situations and inner states of those impacted by present conflicts. Looking back at the line of research on transgenerational trauma transmission, John Bowlbys influence is very apparent. He developed his ground-breaking attachment theory by investigating children who were separated from their parents or suffered from maternal deprivation in the post WWII period in Europe. Not only was he a pioneer in recognizing that infants are born with an innate predisposition to form and maintain attachment relationships, but he also emphasized the critical role that secure attachment has on healthy child development (Bowlby, 1951, 1958; see also Bowlby, Miller & Winnicott, 1939). His theory and further developments remain an important foundation for understanding transgenerational mechanisms of trauma transmission today. Also in the post-war years, Hans Keilson (1979) was the

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first to stress the importance of social and political framework conditions as well as individual and interpersonal experiences when considering trauma. He described the impacts of the Holocaust on Jewish children before, during and after World War II, and coined the term "sequential trauma". He found that the age of the children when the traumatic experiences started was related to the severity of their mental disorder later in life.

It is in the nature of trauma that sorting and understanding begin in the aftermath. Considerable time is needed to process what happened, and mourn the losses of one's home and loved ones. In this way memories and feelings can be integrated into one's narrative and thus a feeling of safety and trust be regained (e.g. Becker, 2006; Keilson, 1979; Zimmermann, 2012). In times of war, flight and building a new life in exile, processing traumatic events is equally important to the mental health of parents and their children. Anna Freud pointed out the importance of parental presence and reactions for mitigating the effects war can have on children early on (Freud & Burlingham, 1943). In line with this, Scorce and Emde (1981) found that it is not the mother's presence alone, but her emotional availability to the child, that fosters exploratory behaviour, thus laying the foundation for autonomy development. In case the caregiver is unable to care for the child, the newborn does not yet hold the capacity to wait until its primary caregiver has recovered from their potentially traumatizing experiences at their own pace. These situations must be identified as early as possible so that the caregiver and child receive adequate support. Both must be addressed at the same time during early interventions. If adequate help is not there in time, difficulties in the dynamic between caregiver and child could become long-lasting, permanently repeated and further intensified (Fraiberg, Adelson & Shapiro, 1975; Moré, 2013). In her pioneering work within the Child Development Project Selma Fraiberg and her colleagues investigated the impact of parents' adverse childhood experiences on the early development of their children. These observations are supported by empirical research from the last decades (e.g. van Ee et al., 2016; Lambert, Holzer & Hasbun, 2014; MacMillan et al., 2021; Murphy et al., 2014). Fraiberg provided a rich framework to analyse early disruptions in parent-child relationships and designed early intervention approaches that took children and caregivers into account (Fraiberg, 1980/2011).

Early pathological defences

It has been shown that disruptions in the relationship between caregiver and child have a major impact on the child's development. Especially when they occur early in the child's life (e.g. Bowlby, 1951; Keilson, 1979). Fraiberg and her team observed a link between parental (childhood) trauma and the ability to care for a child in their clinical work with highly stressed parents (Fraiberg et al., 1975). They also observed significant effects of parental stress and impaired parenting skills – due to parental trauma – on very young children. In her posthumously published paper, Fraiberg (1982/2003) describes various early pathological defences observed in children between the ages of three to eighteen months. The term "pathological defences" refers to behaviours that seemed to be used, even by very small infants, as an extreme adaptation measure in situations where the "functioning" (ibid., p. 567) of the child is at risk. For example, when a caregiver is in a state of depressive withdrawal and therefore unable to regulate or relieve the child's tension or distress. Moreover, the caregiver may even be overwhelmed by the child's affects themselves. This might lead to states of great helplessness. Subsequently, the newborn might selectively avoid this caregiver by not looking at them or turning their body away to avoid the associated affective state. Fraiberg noted how the ongoing "psychologically absence" (ibid., p.563) of the participating mothers in her project affected the development of inner object relations and Ego-functions of their children.

Avoidance behaviour was described by Fraiberg and colleagues (1982/2003) as the first observable defensive reaction, even in children as young as three months of age. This included little or no eye contact, lack of smiling towards the mother and lack of reaching out or approaching the mother even when the motor development would allow for it. The rigidity and selectivity of the avoidance pattern shown by children of highly stressed mothers indicated the pathology, in contrast to avoidance behaviour that can occasionally be observed in any child (see Ainsworth, Blehar, Waters

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& Wall, 1978/2015; Salomonsson, 2016). In addition to *Avoidance*, Fraiberg observed and classified other early pathological defences. Beginning at five months of age, some of the infants showed a complete failure of movement and articulation. A behaviour that Fraiberg referred to as *Freezing*. She considered this behaviour similar to the biological defence of animals in situations of extreme danger. A situation which leads to complete disorganization, because the tension between defence against external threats and the internal stress regulation system cannot be resolved. Another behaviour observed was *Fighting* from the age of twelve months on. She described how children might show fighting behaviour in states of fear and helplessness, also similar to the biological mechanism of fight (vs. flight). Moreover, Fraiberg mentioned *Transformation of Affects* from nine to sixteen months. For example, she described a series of children who displayed theatrical laughter. The commonality of these children was that chronic fear was part of their lives from an early age. In all of these cases, subtle signs of fear were observed before the child responded with a factitious-sounding laugh. Fraiberg postulates that the laughter may function as a defence against unbearable states of fear, although it remains unclear how the transformation occurs. Last, she and her team observed how children, from the age of 13 months, directed their aggression against themselves. For example, a child who neither cried nor approached its caregiver when in great physical pain; a pathological defence, she called *Reversal*. Fraiberg also refers to Spitz (1965), who observed orphans who harmed themselves in their first year of life. In her work, it remains open, how early pathological defence is connected to adult defence mechanisms (Fraiberg, 1982/2003).

Esther Bick's idea of the "second-skin formation" should also be mentioned in this context. In her paper "The experience of the skin in early object relations" (1968) she explains her understanding of the function of the skin as a primary container. The skin, as an outer boundary, holds together the parts of the self that in infants and young children do not yet have coherence and cannot yet be distinguished from body parts. The internal function of holding the parts of the self together results from the introjection of an external object that is experienced as capable of holding the body parts together. Inadequate holding experiences may lead to the formation of a second skin in these infants and toddlers as a protection against the overwhelming fear of disintegration and fragmentation that threatens when the (most often maternal) container cannot provide support. This second skin can be viewed as a substitute of muscles that replaces the normal dependence on the holding object with a pseudoindependence. Manifestations of this early defensive behaviour may include increased activity in addition to this apparent independence and premature control (see also Anzieu, 2022).

Emotional availability

Since the 1970s, emotional availability has been widely used to approach an understanding of the early relationship between caregiver and child. It was first described by Mahler, Pine and Bergman (1975) as a "mother's supportive attitude and presence in the context of infant/toddler explorations away from her. They noted that healthy mother-child relationships allow for exploration and autonomy, at the same time recognizing the importance of physical contact and emotional 'refueling'" (cited by Biringen et al., 2014, p. 115). Later, Emde (1980) alluded the importance of the caregiver's sensitive responsiveness to positive as well as negative stress related affects. Biringen and Robinson (1991) were the first to conceptualize emotional availability in a research context as coming from the integration of attachment and emotional perspectives" (Biringen, 2008, p.5). They emphasized that the child is an equally important part of the dyad and therefore needs to be taken into account when studying caregiver-child-interaction: "…the child's interest and success in involving the mother in play and drawing her into social interaction is also an important aspect of the child's schema or representation of the relationship" (Biringen & Robinson, 1991, p. 262). Although there are different scales for caregiver and child (see below), the Emotional Availability Scales capture emotional availability as a dyadic relationship construct, since "… the emotional availability of both partners is viewed from within the context of this particular relationship" (Biringen et al., 2014, p. 117).

The EA Scales consist of six scales: four regarding the caregiver (*Adult Sensitivity, Adult Structur-*

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ing, Adult Non-Intrusiveness and *Adult Non-Hostility*) and two regarding the child (*Child Responsiveness* and *Child Involvement*). In addition, the EA Zones Evaluation (EA-Z, formerly Emotional Attachment/Emotional Availability Clinical Screener) have been added to summarize the results of the EA Scales. The EA-Z allows the interaction to be categorized into one of four zones respectively for the caregiver and the child (emotionally available, complicated, detached, problematic), thus creating a link to attachment styles (Saunders et al., 2017). The EA Scales can be applied to video recordings, as well as natural settings, and different contexts (at home, in the laboratory, in free play, and partially or fully structured play). For example, for the assessment of free play Biringen suggests a minimum of 20 minutes of video recordings. Construct validity (Biringen & Easterbrooks, 2012), test-retest reliability (Bornstein, Gini, Suwalsky et al., 2006) and interrater reliability (Bornstein, Gini, Putnick et al., 2006) have been demonstrated (see also Biringen et al., 2014).

A short overview is given to enable the reader to better understand the assessment of the then following case study. For a more detailed description of the scales and subscales, see Biringen et al. (2014). *Adult Sensitivity* measures the caregiver's affects, as well as perception and responsiveness to the emotional expression of the child; "e.g., parent having a calm emotional presence and reading a child's emotional cues appropriately" (ibid., p.117). The second scale, *Adult Structuring*, captures the caregiver's attempts and success to structure the interaction/play and to provide a holding frame for the child. The capacity to provide this frame and to be available in the interaction without intrusions on the child's autonomy is assessed with the *Adult Non-Intrusiveness* scale. *Adult Non-Hostility* measures the absence of negative affects in general and hostile behaviour towards the child. For example, the appearance of feelings like impatience or boredom can be seen as covert hostility, whereas open hostility is described as directed to a person and would lead to a lower rating. *Child Responsiveness* "…focuses on the child's emotional and social responsiveness to the caregiver. This is reflected in two aspects of the child's behaviour – affect and responsiveness" (ibid., p.119), while *Child Involvement* "…refers to the child's ability to involve the parent in his/her play and the activity in general, thus including the adult in the interaction. The observer looks at what initiatives the child makes in order to accomplish these behaviors" (ibid., p.119). Each scale consists of seven subscales, relating to certain aspects of the construct, and a direct score, which provides a global assessment of the scale (Biringen et al., 2014; Biringen, 2008). Authorized training and reliability test are necessary to use the EA Scales (see https://emotionalavailability.com).

Early pathological defences inherent in the Emotional Availability Scales

Early pathological defences were not considered during the construction of the EA Scales (Biringen, 2008). Biringen and Robinson (1991) focused on already operationalized constructs, for example proximity-seeking or avoidance behaviour in the Strange Situation Test (Ainsworth et al., 1978/2015). However, some of the subscales seem to represent early pathological defences as described by Fraiberg quite accurately (1982/2003). Although the EA Scales focus more on the dyad compared to pathological defences, Fraiberg also describes the selectivity of pathological defences. For example, Fraiberg also observed child gaze avoidance of the mother but not the father or researchers (see also Salomonsson, 2016). In addition to emphasizing the importance of the dyad between caregiver and child, the EA Scales are the first rating system that incorporates a global assessment of the affective relationship rather than assessing only discrete indicators (Biringen et al., 2014). The seven subscales of each EA scale are partly defined by discrete behaviour descriptions (e.g. Physical positioning and Lack of avoidance on the two child scales). These correspond with aspects of the pathological defences that Fraiberg observed and described. Finally, affect plays a central role in both approaches. Emotional availability refers to "the ability of two people to share a healthy emotional connection, and it thus elucidates the emotional and dyadic quality of relationships" (Saunders et al., 2015, p.2). Early pathological defences are the child's way to regulate adverse affective states which are more likely to occur when caregiver and child aren't sufficiently emotionally connected (Fraiberg, 1982/2003).

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Case-study: Ashtar and Sabri [i]

Migration circumstances, experiences and situation in Germany

Ashtar, a woman in her 40s, was referred to "Strong together!" by hospital staff. During the first home visit, communication was challenging because Ashtar could not speak German and her husband only spoke poor German. Later, Ashtar told us that her marriage was arranged and that she had only met her husband once before the marriage. She said that she felt ashamed because of her older husband and her old age as a first-time mother. After experiencing a long war in the Middle East, Ashtar came to Germany less than a year before her baby was born. Since she arrived, she had stayed home alone most of the time because her husband worked shifts in another city and she was afraid to leave the house by herself.

As part of the project evaluation, she answered the Arabic version of the Harvard Trauma Questionnaire (HTQ) (Mollica et al. 1992; Shoeb, Weinstein, & Mollica, 2007). It was conducted by staff members the mother was most comfortable and acquainted with. This was the only occasion she opened up about her experiences during the war. She reported experiencing a lack of food and water as well as poor medical care and exposure to combat situations. She had felt close to death and witnessed people she didn't know being murdered and kidnapped. Ashtar only reported a few traumatic symptoms (in the non-clinical range of the HTQ). She indicated feeling a little jumpy, having mild concentration and sleep difficulties as well as feeling 'on guard' and blaming herself for the traumatic event. She reported feeling irritable or having outbursts of anger "quite a bit".

First impressions of Ashtar and Sabri

When we (one of the authors and a colleague) arrived for our first home visit, Sabri, the two-month-old baby, was asleep. We were offered cookies and tea and welcomed warmly by the husband. Ashtar stayed in the background and seemed very shy. When they introduced us to Sabri, we felt like they were presenting their child to us as if it was a gift. Her husband held and handed the baby to us in a way that made us feel it was a precious treasure. Soon, the feeling arose that Sabri was being handled more like a thing than as an infant with own needs. Ashtar and Sabri were dressed with great care. This stood in sharp contrast to the simple, improvised interior of the apartment. Ashtar had her husband translate that Sabri was her "prince/princess".

Ashtar often came late to our group meetings and seemed disappointed when the group ended on time. Upon her arrival, she handed Sabri over to my colleague or me, sometimes even without making eye contact with us or commenting. She was talking to the other mothers in Arabic but they told us they didn't know how to relate to her. It seemed that they were often having differences of opinion which made my colleague and me wonder what they were discussing. When we asked, they mostly dismissed it. Ashtar never joined our beginning ritual – a welcoming song for all children and mothers which involves a lot of gesturing. Instead, she stayed in the background and distanced herself from what we were doing with the babies by making fun of us. We wondered if she had difficulties relating to the baby-talk. As group leaders, we occasionally felt that it became difficult to maintain the holding frame during our meetings, as some participants felt offended by Ashtar's way of communicating and her withdrawal from group rituals. There wasn't much interaction between Ashtar and Sabri during the group meetings either. Like described above, she left her baby with other adults most of the time, which felt like she wanted to get rid of it for a while. Occasionally, we also felt that she wanted to give the group the best she had to offer – her child. The interaction we did observe was rather rough and insensitive, when she, for example, offered toys to Sabri, which they couldn't relate to, while she also spoke in a harsh voice.

Video description

The 15-minute video was recorded by a group leader in the rooms of the mother-child groups when Sabri was seven months old[ii]. Throughout the video, Ashtar can be seen holding Sabri while they are facing the camera. Ashtar can also be seen trying to get Sabri's attention by engaging in playful

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interactions. Although Ashtar focuses on her child and is holding them on her lap or arm throughout the clip, physical distance is noticeable. For example, when Sabri is uneasily standing on Ashtar's lap, she chooses to hold them away from her upper body where they could have found support and only holds their waist. In other scenes, Ashtar approaches Sabri by presenting a toy very quickly and too close to their face (described below in more detail) or addresses them in a rather loud voice. Sabri is observed looking into the room or to the ceiling most of the time without making any sounds. At times, when their gaze catches the camerawoman, they keep eye contact for a little while and start to smile faintly, but mostly they are looking around with a blank facial expression.

Here, two sequences of the video recorded mother-child interaction are described in more detail:

> Ashtar seats Sabri on the sofa behind her while using her stretched-out left arm to hold Sabri's back upright. She presents two toy cubes to Sabri by putting them in front of them. Sabri reaches out to one of the cubes, but Ashtar takes the cube out of their hands. Ashtar addresses her child directly multiple times. She waves the toy cube in front of them, the bells inside ringing and catching Sabri's attention. Ashtar dabs the cube into Sabri's face and touches her child's nose. When Sabri doesn't react, Ashtar gets a third cube, building a small tower. Seemingly looking for an interaction with the cubes, Ashtar knocks on the tower, highlighting the sound of the bells inside, but Sabri doesn't show any signs of interest. A little bit later, Ashtar seesaws her child up and down, a movement that seems pleasing for Sabri judging from their reaction. Even though their body position is directed to their mother, their gaze is focused on the camerawomen. There is no eye contact with Ashtar who tries to get her child's attention by vocalizing and clucking her tongue multiple times. After a while, it seems as if by chance, Sabri's gaze briefly catches their mothers for about two seconds before turning away. Ashtar signalizes joy as she continues to cluck her tongue even more, and starts to sing while swaying to her song. However, Sabri stares at the wall again and Ashtar turns her baby's body once more to address her directly so Sabri is looking at their mother's face without making eye contact.

In a second scene it becomes clear how Ashtar approaches her infant to engage them in play and how Sabri reacts to that:

> Ashtar lays Sabri down in a flat position on the sofa. Sabri looks around as Ashtar addresses them directly by saying "Hello!". Ashtar then holds up a toy cube and rattles it in front of Sabri's face. Sabri doesn't react to this, but seems to freeze. Ashtar begins an up-and-down-movement with the cube by touching Sabri's forehead and quickly holding it up again. Every movement away from Sabri's head is accompanied by Ashtar clicking her tongue. After five repetitions, Ashtar rattles the cube again but this time directly in Sabri's face. Both, the up-and-down-movement as well as the rattling of the toy seems to confuse Sabri and prompts them to shortly close their eyes at every down-movement whilst remaining still. After the rattling, Ashtar continues the up-and-down-movement closer to her child's body. This time Sabri reacts with a laughing sound to each downward movement and vocal cue by their mother. This pattern of a downward movement, vocal cue and responsive laughter seems oddly automated. Sabri's responses are more short vocal bursts rather than an infectious genuine laugh.

Discussion of Sabri's use of early pathological defences during the recorded interaction

Throughout the video, it strongly appears that Sabri is avoiding the mother with their limited means. This is described by Fraiberg (1982/2003) as early *Avoidance*. Sabri turns their head away from their mother, even though Ashtar makes a big effort to get their attention. During the single instance of directed eye gaze towards the mother in the first video sequence, Sabri seems to observe their mother closely without an emotional connection, looking *through* or *at* her with a neutral

expression. In contrast, when they are looking at the camerawomen, there seems to be a more seeking and emotional connection. Sabri is seen opening their mouth, smiling faintly and vocalising towards the camerawoman as well as reaching out their hands.

In the second scene, another pathological defence is observable: Sabri *freezes*. The baby does not scream or vocalize, but instead looks shocked and confused. During the abrupt up-and-down movements, which appear to the observer to be like an "attack" with the toy, Sabri only blinks. They don't cry or express fear and discomfort in any other way. However, fear and a struggle to control despair appear in our countertransference and a sense of Sabri's helplessness becomes evident when watching the video. After several more instances of Sabri freezing, joyless sounding laughter follows each up-and-down movement. Happy about her baby's reaction, at last, Ashtar repeats these "attacks" over and over again without noticing how overwhelming they seem for her child. Fraiberg observed *Transformation of affects* only in infants older than nine months. Anyhow, it could be discussed whether Sabri's repeated outbursts of laughter could be understood as an early attempt to transform fear and shock. Displaying behaviour, that seems to please their mother, may be an attempt to maintain a connection to her.

Interaction assessment using the Emotional Availability Scales and possible links to early pathological defences

For the evaluation of "Strong together!" video recordings and the EA Scales (Biringen, 2008) were used to assess mother-child interaction[iii] and to develop ideas for interventions. According to the EA Scales Clinical Screener, the overall interaction between Ashtar and Sabri in the video recording can be described as *detached* and *avoidant*. There is barely any emotional connection noticeable, yet Ashtar makes efforts to interact with her infant. She tries to get Sabri's attention by presenting toys to invite them to play. This shows that Ashtar has a wish to approach her child, but is lacking the sensitivity to do so in an attuned way. Therefore, the interaction was not rated in the so-called *problematic* range (in the sense of the EA Scales) in which disorganized and traumatized interactions are classified (see above). A medium score on the Adult Structuring scale was given due to Ashtar's attempts to approach her child rarely being successful, seeming repetitive and varying between too much and overwhelming whilst repeatedly lacking a "supportive frame" (ibid., p.39). Furthermore, there are a few signs of overt distress and hostility towards her child during interactions in the video. Ashtar appears stressed and impatient during the video, such as when she asks whether the video was over after six minutes or during the up-and-down movement of the toy, which appeared quite aggressive and abrupt. However, since she was mostly able to sufficiently regulate these emotions and no major lacks were visible during the video recording, a rating in the medium range on the *Adult Non-Hostility* scale was given.

On the *Adult Sensitivity* scale, the interaction between Ashtar and Sabri was rated as "somewhat insensitive". Ashtar doesn't seem to be able to even pick up clear cues from her child. For example, she couldn't perceive her baby's fear when she is moving the toy toward their face too quickly and too close. Also, there is barely an emotional connection observable. Ashtar seems to have knowledge and ideas about how to interact with a child, such as trying to interest them in a toy, but seems blind to her child's expressed needs and affects. Everything she does seems to follow her plan and is accompanied by loud sounds and verbalizations, which do not seem to reach Sabri emotionally. Her affect neither seems warm, nor authentic. Although she is smiling most of the time, no warmth and affection appear in her face or voice. This can also be felt in the countertransference when watching the video. Overall, because Ashtar tended to approach her child in an overstimulating and overwhelming way during the video, the interaction was rated in a lower range as "somewhat intrusive" on the Non-Intrusiveness scale. She often handles her child physically, moving them around without talking to them and changing their position without need or announcement. In addition, she is intrusive in her play when she puts the toy cube too close to Sabri's face or takes toys out of their hand or sight even when Sabri still seems to show interest in them.

A lower score on the *Child Responsiveness* scale was given, because Sabri already shows several signs of impaired affect regulation and a lack of

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responsiveness to their mother. Sabri already appears to over-regulate their affects, such as when they seem to freeze instead of cry (as described above). This early reaction is described by Fraiberg (1982/2003) as *Freezing* – a complete lack of movement. At this age, Sabri is not yet able to physically move away from the interaction, but there are many instances of averting their gaze away from their mother by looking into the room or towards the camerawoman. Here one could see and discuss the aspect of selectivity that Fraiberg describes as early *Avoidance*: Sabri seems to avoid eye contact, particularly with their mother but not with the camerawoman. Even though Ashtar tries to get their attention, Sabri seems absent and withdrawn. On the *Child Involvement* scale, the interaction was also rated in a lower range, partly due to Sabri's young age limiting their ability to start and maintain an interaction. However, even the ways young children do engage their caregivers during interactions (such as smiling and looking in their caregivers' direction or making sounds), were not observed in Sabri. On the contrary, Sabri often directed their gaze away from their mother or pulled their hands back to their body as if to avoid body contact. The *Child Involvement Scale* also looks at behaviours, which Fraiberg (1982/2003) described as early *Avoidance*, such as (lack of) *Eye contact* or *Body positioning*.

Discussion

Although Ashtar did not reveal much of her history, the assessment of the traumatic history of participating mothers with the Harvard Trauma Questionnaire (Shoeb et al., 2007) allowed us to know that she survived war in a Middle Eastern country. She had witnessed the murder and kidnapping of people and lived under precarious conditions during and after the war. Later, she left her family and moved to Germany by herself to marry a man she did not know before. In a foreign country, without social bonds and knowledge of the language, Ashtar stayed alone with her experiences. She reported being irritable and having outbursts of anger which is a strong indicator of unprocessed traumatic experiences, especially in this context (e.g., Augsburger & Maercker, 2020). An expression of this was observed on several occasions during the video recording and from the group leaders' report. For example, she is seen talking with her baby in a loud manner, making irritating sounds and giving observers the impression that she "attacks" Sabri with the toy.

Overall, the interaction between Ashtar and Sabri during the video recording doesn't appear to be in the disorganized or traumatic range, but there are multiple signs of detachment and disruption and the beginning of defensive organizations in the dyad. This is an impression that was also supported during discussions with the group leaders. The interaction mostly appears to be characterized by emotional and physical detachment with interruptions when Ashtar approaches Sabri in a rather insensitive, intrusive, and overwhelming way (see EA Scales descriptions). A similar interaction pattern was observed in the FIRST STEPS Project in Germany with a traumatized mother who survived persecution in her native country (Fritzemeyer, 2016). It can be further discussed whether the emotional detachment observed and assessed with the EA Scales in this present case was a result of a vicious cycle of repetitive empathic failures. It could be that disintegrated traumatic experiences were triggered when Ashtar was confronted with her baby's natural state of helplessness. This may have led to Ashtar struggling to contain her own feelings of helplessness and the passive intrusion by violent impressions. Ashtar, therefore, rids herself of feelings of anger and helplessness by means of projections and fails to contain the baby's natural state of helplessness and distress. Similar findings of traumatized mothers have been reported by Schechter and Rusconi Serpa (2013). They described traumatized mothers misinterpreting their babies' separation anxiety and feeling of helplessness, expressed by kicking and screaming, "as anger, coercion or other threats" (ibid., p. 233). These observations are supported by results from quantitative evaluations of the EA Scales in the FIRST STEPS project: Mothers, who fled war and persecution were found to be less sensitive, less structuring, and more hostile in their interaction with their babies that mothers who had migrated to Germany for social or economic reasons (Fritzemeyer et al., 2019). It is also in line with a recent study by MacMillan and her team (2021), who found a direct effect of stressful life events occurring around childbirth on emotional availability six

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months post-partum in a sample of mother-child dyads in Australia.

Early effects of this interplay between emotional detachment and intrusiveness on Sabri became visible. Maybe Ashtar's attempts to establish contact with them are too intense for Sabri so they withdrew. Sabri avoids having eye contact with their mother, and seldomly reacts to her invitations to engage in interactions. Sabri also appears to be shutting down their affective expressions even if approached in a way that should cause shock and fear in a child of this age. Not only does Sabri not scream or cry, but they may also already be turning the feeling of shock and fear into a joyless-sounding laugh. Maybe something that satisfies their mother and allows them to maintain a connection through this uncomfortable play. These observations are represented in the EA Child Scales and subscales description and led to a lower score therein. In the aforementioned study by Fritzemeyer et al. (2019), there was also a statistical tendency for the children of mothers who experienced war, persecution and flight to show less responsiveness and involvement with their mothers. This is a tendency we hope to investigate further with a larger sample of mothers, who experienced war or persecution, in future studies.

The herein provided case study highlights how severely and how early on interactions between a parent and child can be compromised by past traumatic experiences. Even experiences of long ago can have a major impact on the bond between caregiver and child. By means of this case study we have tried to show how important it is, to identify disruptions in parent-child relationships as early as possible, as they can only then be addressed appropriately and in time. The concept of pathological defences proved to help detect and describe the early manifestations of an impaired early relationship, as well as changes and adaption within the child. They can be observed relatively easily in the video-taped interaction between Ashtar and Sabri by professional staff. Furthermore, when diagnosing early relationship pathologies, early pathological defences help to take the child's experience in the dyad better into account. The observations enable the staff of "Strong together!" to think about associations with the caregiver's behaviour and formulate initial hypotheses about potential underlying dynamics. In this case, it allowed a better understanding of how Sabri's avoidance could be related to their mother's insensitive attempts to establish contact. This understanding is helpful to develop concrete but sensitive and understandable interventions. For example, the group leaders could make Ashtar aware of how Sabri could feel when they are approached like this, without offending or further destabilizing her capacity to raise Sabri. Also, maintaining a holding, warm and stable environment in the weekly group meetings will allow Ashtar to get in contact with her fragile and abandoned parts, so she could be enabled to see and meet those in Sabri in a more sensitive way. Through the group experience, she is offered the chance to repeatedly make the experience, that she is invited even when caught in negative affects. When she is able to internalize the group as something safe and stable, this experience could allow her to build social bonds in other ways than mocking others or simply handing over her child. In our experience, psychoanalytic supervision for the group leaders is essential for maintaining such an environment. It gives the group leaders the time and space to identify and reflect on their own aggressive and rejecting impulses, as well as feelings of being overwhelmed and of helplessness. This is important, so that they do not act them out in contact with mothers.

When looking at the EA Scales (Biringen, 2008), all pathological defences (Fraiberg, 1982/2003) can be found within the child scales' descriptions. The great commonality between the psychoanalytic concept of early pathological defences with widely acknowledged attachment and development psychological perspectives not only supports its significant relevance until today. Fraibergs concept could also hold the potential to benefit staff in the clinical work with highly stressed, migrated parents and children due to its comparatively easy applicability and related practical implications. This has to be investigated further with more case studies and over a longer time period in close collaboration with the practicians.

Limitations and future research

Since this is only the investigation of a single case, it must be stressed that the early defence reactions observed in this mother-child interaction cannot

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be generalized to other parent-child dyads. Also, Bornstein, Suwalsky and Breakstone (2012) describe emotional availability as independent from "culture, place of residence or socioeconomic status" (ibid., p.114), since a reciprocal emotional communication can be considered essential for a child's development anywhere. The EA scales have been used in over 22 countries with good validity and reliability results (Biringen et al., 2014), but some systematic variations have also been found in the few cross-cultural studies that exist (Putnick, Bornstein, Breakstone & Suwalsky, 2014). This limitation also applies for the assessment of trauma with the HTQ. Results might be influenced by social desirability, a different understanding of psychic stress, stigmatization or a highly rigid defence in order to live with the experiences of violence and isolation (Leuzinger-Bohleber & Fritzemeyer, 2016).

Further research should aim to examine whether these observed patterns can also be found in larger samples of refugee parent-child dyads. And if yes, to ask whether those patterns are more likely to arise in dyads with war traumatized parents. Secondly, it would be helpful to closely observe individual developmental trajectories in a repeated measurement design to better understand the impact of the *ghosts in the nursery* in exile over time. This is important because, if not appropriately addressed, the observed difficulties between caregiver and child could lead to lifelong distress and mental health issues for subsequent generations (e.g., Greenspan, 2007; van der Hal-van Raalte, van Ijzendoorn & Bakermans-Kranenburg, 2007). Initial results of the FIRST STEPS project give hope that professional early prevention can have a positive impact on some aspects of emotional availability (Lebiger-Vogel, Rickmeyer, Leuzinger-Bohleber & Meurs, 2022). Supervision and training have proved essential to get in contact with this hard-to-reach and high-risk population whilst offering and maintaining a supportive and stable relationship (Fritzemeyer et al., 2019). Sadly, there are only a limited number of prevention projects that professionally support early parent-child relationship in exile. This is especially disappointing because it is not only widely known but also supported by empirical evidence that people who flee from war and crisis zones are at high risk of developing mental health problems which can potentially compromise early relationship experiences (e.g. van Ee, Jongmans, van der Aa & Kleber, 2017; Fritzemeyer et al. 2019).

Keywords: early pathological defences, emotional availability, parent-child relationship, trauma transmission, early prevention, war, migration

Acknowledgments: Many thanks to Annina Dittman for her thoughts on the case study and the entire team of "Strong together!" for continuing their work under ongoing difficult conditions, due to the COVID-19 pandemic and unsteady project funding. We wish to thank the MAHLE-Foundation (www.mahle-stiftung.de) for funding the project evaluation and Prof. Tamara Fischmann (International Psychoanalytic University Berlin) for her support therein as well as the community prize committee of the International Psychoanalytic Association to grant us the community prize in the category "Violence" in 2021, and to Marianne Leuzinger-Bohleber for her continuous support.

Footnotes

[i] All personal data was anonymized actively to rule out any possibility to backtrack. Participating mothers gave their written informed consent to take part in the study. Also, the gender of the child is anonymized by using the pronouns they/them.

[ii] In accordance with recommendations by Biringen, at the beginning of the videotaping, the camerawomen provides the instruction, that the videotaping will last approximately 30 minutes and that she and her baby will be recorded interacting the way they normally interact (feeding, diaper changing etc.). They should not look into the camera but pretend that it is not there – which of course is challenging, but we know from research that among healthy caretaker-child-interactions the videotaping does fade into the background when caretaker and child interact intensively.

[iii] Videos are scored by the first and second author of this paper, both certified raters of the Emotional Availability Scales (Biringen, 2008).

Summary

Not only did Selma Fraiberg develop her widely known concept of ghosts in the nursery (Fraiberg, Adelson & Shapiro, 1975). She was also one of the first to describe pathological defences in infants (Fraiberg, 1982/2003). Her concept of pathological defences, developed in the 1980s, proved to be very helpful to understand the first manifestations of caregivers' distress on their newborns and infants. Even at an age, when children have not yet developed an Ego in the narrow sense, they show behaviour, which can be understood as a defence against threats to their functioning. This article aims to describe such defensive behaviour in an infant, born in exile, of a mother, who survived war in a Middle Eastern country and to explore how early pathological defences are related to emotional availability, measured with the Emotional Availability Scales (Biringen, 2008). An initial hypothesis about how the development of the pathological defences observed can be associated with the mothers' traumatic distress and what can be drawn from that for early prevention of transgenerational transmission of traumatization is being formulated.

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Presentation of authors

Korinna Fritzemeyer, Ph.D., is a psychologist and training candidate at the Berlin Psychoanalytic Institute. In her research and practical work, she focuses on understanding and preventing transgenerational effects of trauma as a result of collective persecution and migration. Since 2012, she has coordinated the evaluation of FIRST STEPS and subsequent projects such as "Strong together!" and is currently a guest scientist at the Psychologische Hochschule Berlin, deputy chairwomen of the Jiyan Foundation for Human Rights e.V., and child protection appointee of Wildfang e.V. for foster and adopted children.

Janina Mehner-Gentner, M.Sc., is a psychologist and training candidate at the Esther Bick Institute Berlin. Since 2018, she has been part of the early prevention project „Strong together!" (formerly FIRST STEPS/Berlin). In her research, she focuses on the concept of mentalization and especially on parental reflective functioning in the context of transgenerational effects of traumatization.

Lena Schestag, M.Sc., is a psychologist and training candidate at the Psychologische Hochschule Berlin. Since 2016, she has been part of the early prevention project "Strong together!" (formerly FIRST STEPS/Berlin). Currently, she is working on her PhD project "Sequential traumatization in the context of war, persecution, flight and forced migration and its impact on early mother-child interaction" with Prof. Patrick Meurs (University of Kassel).

Email addresses of authors

lena.schestag@gmx.de

janina_mehner@yahoo.de

k.fritzemeyer@dpv-mail.de