

EFFECT OF THE MOTHER'S EMOTIONAL ATTITUDE ON THE INFANT

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Despite the folklore and the voluminous old wives' tales relative to prenatal influence, little scientific attention has been devoted to detailed observation of the effect of the mother's attitude on the child before or after birth. Little is known about prenatal influence although there are a few respectable scientific clues.

Dr. Hooker, Dr. Sontag and others have sur-

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prised many of us by their data relative to the reactions of which the embryo and foetus are capable. In view of our knowledge of physiological mechanisms, most of these reactions could be assumed to be more or less subject to influence by the psychosomatic state of the mother. The physiology of the mother is changed when she is under emotional strain and the effect of these changes is transmitted to the foetus through the placental circulation and in other ways. But pending accumulation of more information in this sphere, the effect

of the mother's attitudes on the infant presents a fertile field for investigation.

Because Dr. Fries plans to present some objective data relative to psychosomatic relations between mother and infant, the following comments are based largely on clinical observation rather than on experimental data. On the one hand there is the fact that the infant is less adequately equipped than most new-born animals to cope with extrauterine environment. On the other hand the human mother in our culture is in many ways less well equipped to deal with the infant's helplessness than most mammalian mothers. These facts in their interaction create problems for parents and children, and disorders in society.

Certain characteristics of the infant serve to render it particularly sensitive to the impact of the maternal attitudes. First, from the point of view of the soma the process of myelinization is a gradual one, probably differing from infant to infant, although the all-or-none response to most stimuli is a characteristic of the new-born. Second, from the point of view of the psyche, or the developing personality, the infant has not learned to differentiate itself from its environment and hence is easily confused and very suggestible. Third, from the moment of birth, the infant is confronted with the problem of integrating diverse types of experience, all the while handicapped by an inadequate receiving apparatus and an inadequate capacity to assimilate and correlate.

From the study of these and other well known characteristics of the new-born, it is obvious that to the long list of the more mechanical noxious agents to which the infant is exposed there must be added many exogenous influences. Among these the following deserve special emphasis:

1. The factor of emotional contagion
2. The possibility of trauma from exposure to intense adult emotion
3. The susceptibility to exhaustion through over stimulation
4. The inhibition of growth through over-protection or over-training

Of these, perhaps the most frequently overlooked is the infant's susceptibility to what has been termed "*emotional contagion*." What is meant by this term is illustrated by the following story:

A four-months old infant who had been eating liver soup for about a month, with great enjoyment, was suddenly reported to be unable to tolerate liver. What had happened was that the mother who usually fed the infant had asked the child's great-aunt to take care of the noon feeding once a week when it was necessary for her to remain on the job. The mother happened to return home on one of these days and paused outside the

nursery door to see what was going on. The great-aunt was saying, "Mary, just one more spoonful of that nice liver." The child was making faces and spitting it out. The mother detected an expression of disgust on the great-aunt's face. She then said to the great-aunt, "Won't you stay and have lunch here? We are having liver and bacon." The great-aunt replied that she would rather eat in a cafeteria than eat liver and bacon. She said: "I think it is disgusting to eat the insides of animals." The mother handled this situation by never ordering liver for the infant on the days the great-aunt was to be there, and the child continued to eat the liver with great relish whenever it was given to her by her mother. Had the great-aunt been the infant's nurse instead of an occasional visitor, the mother and the pediatrician probably would have decided that liver disagreed with the infant because of heredity or constitution, and the infant much later probably would have said that liver disagreed with her and this food intolerance might have become a physiological habit.

There was a further incident illustrative of a similar emotional contagion. The infant previously had enjoyed egg yolk. The great-aunt suddenly reported that that too disagreed with the infant. The mother then said: "Don't you like eggs?" The great-aunt replied: "Yes, of course. But not all dried up the way you feed them to that poor baby." The mother asked the great-aunt how she would fix them and the great-aunt replied that she would fix them with a little milk and butter. The mother replied: "Fix them the way you like them and give them to her." After that the baby was able to tolerate egg yolk with milk and butter when the great-aunt fed her, and in the previous less attractive form when the mother or father fed her.

Since feeding is the focus of the first emotional relationship established between mother and infant, and a major element in the relationship between pediatrician, mother and infant, it would be desirable to include in every textbook for pediatricians, and in every handbook for mothers, the suggestion that there is probably no point in prescribing for the infant any food substance for which the mother, nurse, or whoever is in charge of feeding, has a definite dislike. Fortunately, today an adequate substitute can be found for almost every ordinarily prescribed item in the infant's diet.

But while parents, infant and pediatrician are focusing their attention on such practical problems as these, the infant is also struggling to become aware of itself as an individual. The contagion of parental attitudes probably is most marked for better or for worse in relation to ego development. Even if the doctor, or the mother herself, does not know whether the infant is really wanted, the infant usually seems to get a pretty good idea of the relationship. This is independent of whether or not the mother has decided to nurse it. A rejected or hated infant, whether it becomes crushed

and lonely, or whether it rebels, is likely to incorporate in its idea of itself its impression of what its parents think of it. Even such details as calling an infant "it" instead of "he" or "she," or "baby" instead of "you" or by its own name, may have an effect on future development. Babies who are regarded as playthings or mere objects of affection tend to remain infantile longer, and they are more likely to become sick than those who are treated as human beings.

The intensity of the emotional contagion is, of course, greatly modified by the parents' capacity to be objective. The electrical potential of the emotional atmosphere in which families live may reinforce or diminish the element of contagion.

Exposure to *intense adult emotions* is traumatic to the developing personality of the infant. Weathering a storm of parental rage may bring about a traumatic neurosis like that frequently observed in survivors of Dunkirk. The infant who can get through its first year without exposure to its parents' hostility or sexual tension is likely to have fewer psychosomatic symptoms. This seems to be true even if the child is not the focus of the hostility or sexual interest, because in any case he is inevitably caught up in the mother-father-relationship. Even exposure to emotional outbursts in siblings may be traumatic because a child, only one or two years older, is vastly different in its physical capacities and in its emotional defenses from the infant. Of course children usually express rage or sexual tension almost from the moment of birth, but they do better when their first exposure to rage in others occurs in situations with their contemporaries.

Many parents who are careful about exposing the infant to overt expressions of their own emotional conflicts are nevertheless unaware of the many little ways in which these conflicts still may have an influence. Although the infant needs a sense of love and security, and assurance that the parents will be available to meet needs as they arise, it also needs to be left alone and to be allowed to experiment by itself. The compulsion to be constantly with the child in everything it does, or to keep it constantly entertained, may bring about *exhaustion through over-stimulation*. The parent who is always with the child can scarcely avoid overstimulating it, although at the same time this parent easily may become sufficiently annoyed by its demands to fail to respond promptly enough when the child is waiting for food or dry diapers, or reassurance when frightened. Waiting is much more difficult for the infant than for the adult, so that the ideal would be to study the problem of timing, leaving the infant alone as much as possible but never failing to

respond to a definite need. Sometimes the need to be entertained is important too. Infants like the rest of us may suffer from boredom. Symptoms like sleeplessness, restlessness, fear of the dark, nightmare, diarrhoea and constipation, can be often avoided or eliminated if the parent is careful in these respects.

Inhibition of growth through overtraining is also of frequent occurrence. Just as the infant should not be expected to make up for the emotional frustration of the parents, it should not be expected to become the kind of person the parent *wanted to be*. Too much concern about the child's development, too much interest in providing the ideal routine and training program, may interfere just as seriously with development as emotional smothering. Insofar as possible the infant should make its own experiments, should learn to not put its fingers in the fire because the fire is hot rather than because the mother says "no." Often if no somatic symptoms result from such pressures, behavioral patterns may be occasioned which favor the development of somatic dysfunction and damage later in life.

Of course the points just outlined are familiar, but too much emphasis cannot be placed on the value of careful investigation of the role which may be played by one or all of them in connection with behavior problems and illnesses in early infancy. If such injurious influences are eliminated from the infant's early environment, many childhood disorders such as constipation, susceptibility to colds, indigestion, allergy, can be prevented from becoming chronic or even completely avoided.

Many illness tendencies of adults which have been labeled hereditary or constitutional have their background in childhood injuries brought about by faulty emotional attitudes in the parents. The human being is never so susceptible to this type of damage as during the period of infancy. Physicians aware of this fact can interest the parents in observing the child and develop in the parents an attitude of cooperation which is sympathetic and objective rather than frightened. Only too often well-meaning physicians call the mother's attention to the far-reaching effects of her emotional attitudes on the child in such a way as to activate her insecurity, or even guilt, rather than her capacity for understanding and confidence.

A review of 1500 serial admissions to a general hospital, of patients suffering from diverse cardiovascular disorders, diabetes and fracture, emphasized the lack of evidence for hereditary factors in these syndromes. Most medical textbooks stress heredity of cardiovascular diseases in discussing

these diseases, and ignore such heredity in patients suffering from other illnesses. In this series it was found that the incidence of cardiovascular heredity was nearly equal in all the groups studied, whether or not they had any cardiovascular disorder. Patients admitted for fracture, with no cardiovascular symptoms or damage showed just about the same percentage of cardiovascular heredity as patients admitted for hypertension or for coronary occlusion. Indeed, if one were to use statistics of hereditary incidence in the customary way, one would have to conclude that accidents are hereditary since the parents and siblings of fracture patients had an extraordinary incidence of accidents of all types. These seeming anomalies are eliminated, however, when one changes the basis of the statistics to disease incidence among those to whom the patient was *exposed*—including friends and relatives by marriage. There had been more exposure to cardiovascular diseases among patients suffering from these illness than among patients in

any other group. Often there was a history of having lived with, or having nursed a parent in an acute terminal phase of the disease. Whether what we have come to call pseudo-heredity is a matter of early catching of emotional tension and bad habits of living from those intimately associated with the patient in infancy, or whether many more factors are involved, is still a question, but the susceptibility of the young child to emotional contagion must be considered in any discussion of heredity or constitution.

If establishment of illness habits can be avoided in infancy, many of the most baffling chronic diseases of later life may be eliminated or ameliorated. Certainly it would appear from the evidence now available that the incidence rate of many such diseases can be greatly decreased. In brief, the sphere of investigation undertaken by the Committee on Psychosomatic Problems in Pediatrics represents a frontier in preventive medicine.