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REFLECTIONS ON SPECIAL-CARE BABIES AND THEIR EARLY EXPERIENCE

ANNE McFADYEN

SUMMARY

In this paper the author presents some ideas about rapprochement and reciprocity, and considers them in relation to the experience of special-care babies and their mothers. Psychoanalytic infant observation is discussed in the context of the relationship between psychoanalysis and developmental psychology and its value as a method of research is explored. Observational research has contributed to the understanding of early mother-infant relationships, and in particular has highlighted the importance of reciprocity and fit. The crucial importance of this in relation to premature babies' early relationships is illustrated by the presentation of extracts from the observations of three mother-child pairs during their stay in a special-care baby unit.

INTRODUCTION

In this paper I hope to convey some of my thoughts on the contribution which psychoanalytic infant observation can make to the understanding of the early psychic experience of premature babies. Although the value of infant-observation in the training of child psychotherapists and others has been recognised (Bick 1964, Miller et al. 1989, McFadyen 1991), its potential to inform theories of infant development has probably not been fully accepted. Psychoanalytic infant observation may be seen as the epitome of a rapprochement between two theoretical schools. In other words, it represents the coming together and application of ideas from psychoanalysis and developmental psychology. This relationship will be considered in more detail in the first part of this paper.

My second theme is reciprocity, which in the special-care baby unit may be between infant and parent (mother in the majority of cases), infant and nurse, or nurse and mother. The contribution which each person, and, more importantly perhaps, each relationship, makes to the baby's developing sense of self and the baby's developing relationships is considered. Finally, I will present some observational material which was collected in the context of a study of special-care babies and their...
developing relationships, the findings of which are presented more fully elsewhere (McFadyen 1994).

**Rapprochement**

A number of authors have discussed the relationship between psychoanalysis and developmental psychology, and it is fair to say that within the last ten-to-fifteen years there has been an enormous shift in attitudes, which has led in most quarters to a sense of mutual respect, and in some cases to a more intense relationship between the two. Urwin (1986) has commented on the ‘considerable borrowing’ which has taken place between the two disciplines.

Bentovim (1979) asked whether it was legitimate to attempt to integrate child-development research and psychoanalytic theories, and acknowledged the ‘considerable opposition to such attempts’. These objects came from those who challenged the biological and evolutionary context of psychoanalytic theory and labelled it as ‘subjective, endopsychic and non-scientific’. Slater (1975) was reported to have observed that Freud’s theories were especially well adapted to sustain what he felt was a ‘necessary delusion’.

We could probably refer to all theories, psychoanalytic or not, as necessary delusions. This description seems rather pejorative, but fits with a ‘new science’ view of the world. One of the helpful implications of the resurgence of constructivism as a premise in the scientific world is the acceptance of the notion that each individual’s view of the world has equal validity, that is, it is as true as anyone else’s. We each use particular theoretical models to help us to understand the world, to ascribe meaning, and to keep anxiety about not knowing at bay. Psychoanalysts, of course, have always recognised the centrality of this idea in relation to their clinical work, that is, to the experience of their patients and to their practice, if not also to their own belief systems. Winnicott, who was both a psychoanalyst and an observer of babies, appears to have shared this view. One of his statements, which appeared to be directed at infants, seems also to have summed up the constructivist philosophy:

> Come at the world creatively, create the world;  
> it is only what you create that has meaning for you (Winnicott 1968).

The subjective component to scientific thinking is now not only accepted but seen as vital; so that, in Bentovim’s words,

> psychoanalytic theories and proposition about subjective experiences must be taken seriously (1979).

The potential of these theories to offer possible explanations for empirical findings, and to generate new hypotheses, has been welcomed, and in the 1970s these theories were starting to be recognised by developmental psychologists as an antidote to the idea that the infant’s experience of the world was simply as ‘one great blooming, buzzing confusion’ (James 1890). The focus of child-development research can be seen as having moved away from the study of the impact of caretaker on infant to...
the study of the effect of the infant on the caretaker, and, more recently, of course, to the nature of the fit between the two, with the recognition that there is a need to look beyond the characteristics of the parent and the infant to understand what transpires between them (Belsky & Isabella 1988).

Much of this research takes place in the laboratory situation, while some is more ethnographic. The conclusions tend to be based on the infant’s observed behaviour, while in a state of alert inactivity, but nonetheless they have contributed to a radically altered view of the infant’s capabilities and the course of development.

The ‘looking back’ through the minds of adults or children to infancy has provided a different kind of evidence about development, and in particular psychic development. In Gosling’s terms (1968):

States of mind are seen as deriving from the impact of a present situation on a mind already patterned by previous experiences, each of which has had an impact and left some residue.

In psychoanalysis, the examination of the pattern and the residue may contribute both to a therapeutic outcome for the patient, and to an understanding of the nature of development for both patient and analyst. Crown (1968) considered that one of the problems inherent in the use of psychoanalysis as a developmental theory was that the methods used to draw conclusions were not particularly easy to scrutinise. In some ways, the flourishing of developmental psychology and the recognition of the value of anthropological research have been useful in helping to support some psychoanalytic ideas.

The essential difference between the two schools is that one has a set of theories which are in effect post-dictive, while the theories of the other are informed by actual observations of babies in the here-and-now, and as such have the potential also to be pre-dictive. Stern (1985) referred to these differences as representing a split between the ‘clinical infant’ and the ‘observed infant’. He described the former as the joint creation of two people, the adult who grew up to become the psychiatric patient and the therapist who has a theory about infant experience. The recreated infant is made up of memories, present reenactments in the transference, and theoretically guided interpretations.

Stern has touched here on one of the more legitimate criticisms of psychoanalytic models of infant development, namely, that on the whole they have been developed as a result of the investigation and treatment of psychopathology. Another criticism of psychoanalysis as a theory of development related to the differences between theoretical schools. The story created about infancy might be quite different depending on whose ideas the therapist is most married to.

In relation to the observed infant, Stern said that to relate observed behaviour to subjective experience, one must make inferential leaps.
These leaps, of course, cannot be made from an atheoretical position. In Stern's words, 'we require insights from clinical life'.

**Infant Observation**

Psychoanalytic infant observation is a method of observation, or research, well suited to the task of relating observed behaviour to subjective experience. It is not only informed by psychoanalysis; it is also informed by a belief in the importance of the analytic method, and, in particular, in the importance of holding on to the capacity to 'not know'. Carrying out an infant observation provides an opportunity for psychotherapy trainees to develop this capacity, while also learning first-hand about infant development (Miller *et al.* 1989).

Waddell has summarised some of its key features:

The practice of infant observation derives from a particular way of seeing; one which links the analytic process to the observational method initiated by Esther Bick... It is a method with no claims to impartiality or objectivity. Rather the reverse, it is rooted in subjectivity of a particular kind — with the capacity to look inward and outward simultaneously (an aspect of character described by Wilfred Bion as 'binocular vision'); one that struggles to prevent observation being clouded and distorted through preconception. It is a method which requires the observer to be as minutely cognisant of his or her internal processes as those of the subject of the observation. The method reaches to the heart of the analytic relationship, making particular demands, which are well expressed in Keats's notion of 'negative capability' — the capacity to be in doubts and uncertainties, not to reach after irrefutable fact and reason (Waddell 1988).

Psychoanalytic infant observation is a method which brings together the 'observed infant' and the 'clinical infant'. *Psychoanalysis* informs both the method and the interpretation of the data. However, it only become the epitome of true rapprochement when we begin to use the observational data to inform psychoanalytic theory. I believe that the relationship between the observed and the interpreted should not be a linear one. It should not be uni-directional or one-sided. It is a circular relationship. The word 'rapprochement' suggests this, but while there is evidence in the literature of observational research endeavours being recognised as useful in affirming psychoanalytic ideas, there seems to be little indication that detailed observation has, in recent years, contributed to any radical shift in theory. This may be because there is no more to contribute. Our original sources, who were inspirational in their day, and are so even now when discovered or rediscovered, may just have got it right. However, as noted earlier, the belief systems of the data interpreters, or therapists in the clinical situation, may vary widely. The Freud-Klein controversy may have been at its height in the 1940s, but it has not gone away (Segal 1982).

Of course, there are exceptions. Some authors have revised their theoretical
position in the light of observational research. Tustin (1992), for example, in the revised edition of her seminal text *Autistic States in Children*, talked of 'revised understandings' leading to greater freedom and clarity:

Recent observational studies of babies ... have shown us that, in normal development, there are periods of lively, alert awareness and active questing even from the beginning of life. ... use of the concept 'normal primary autism', as implying that there is a stage in earliest infancy when the normal infant is totally unaware of being separate from the mother’s body, is incorrect in view of the objective findings of those infant observers who have been cited. ... I have realised that the extrapolation from pathological conditions, to see them as being an exact reproduction of features of normal early infancy, inevitably leads to error. (Tustin 1992).

Alvarez (1992) too has drawn on observational research to develop further her theory of 'reclamation' in relation to work with autistic children, which will be discussed further on in this paper.

More dramatic, perhaps, is the contribution to theory which has been made by Piontelli (1992). She has tried to draw some preliminary conclusions about early mental life from in-utero ultrasound observations which she continued with through the infancy of a small number of subjects. Piontelli’s observations seemed surprising, in that she appeared to have randomly ended up with a sample in which there appeared to be major psychopathology from the outset. This may throw some doubts on the generalisability of her findings. Her conclusions are of interest nonetheless. Her main propositions are that there is behavioural and psychological continuity from pre-natal to post-natal life, which is not interrupted by birth, and that there is evidence of some rudimental ‘me-not-me’ differentiation; in other words, she proposed that ego-formation begins before birth. Winnicott, who said that

at the beginning the baby has not separated off what is not-ME from what is ME

may have actually agreed with this view. In a paper called 'The Beginning of the Individual' he talked about 'psychology becoming meaningful' during the life of the foetus (Winnicott 1966).

The state of the ego in the earliest months of infancy may be considered to be the issue at the heart of the Freud-Klein controversy. In Segal's words:

It is an important and real controversy about matters of fact, and naturally any views about what is experienced by the infant must be based on a picture of what his ego is like at any given stage. Any meaningful description of the processes involved must start with a description of the ego (Segal 1982).

The key difference relates to the degree of organisation of the ego. Although Freud’s view is commonly understood to be of an undifferentiated ego at birth, Segal has
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drawn attention to the fact that, in some of his concepts, he did seem to imply the existence of an early ego. Klein was much more specific. She believed that a primitive ego existed from the beginning of life outside the womb, that is, that

sufficient ego exists at birth to experience anxiety, use defence mechanisms and form primitive object relations in phantasy and reality (Segal 1982).

Klein saw the infant as having to defend against anxieties from both the external and the internal world. Conflicts exist in both arenas: the outside world can be warm and nurturing, or cold and empty, and the inner world is characterised by the conflict between innate life and death instincts. The former pushes the infant towards physiological and psychological growth, and, more importantly, might be considered to drive the infant from a state of unorganisation to integration. The relationship between the ego and the life instinct seems to be ambifinal, that is, each defines the other. From another angle, the ego’s natural tendency towards integration might be considered actually to be the life instinct. Disintegration occurs under the influence of the death instinct. There is a fear of something that destroys from within, which is experienced phobically, that is, as if it was outside (Symington 1986). This latter concept, central to Kleinian theory, does not seem to have a place in early Freudian theory.

Premature Babies

Klein did not have the opportunity to consider how her theories might be applied to infants born too soon. Neonatal intensive care can now support the lives of babies born as early as 24 weeks’ gestation, who are often in a very real life-or-death situation. These babies are obviously pre-mature, not yet ‘developed’, but does that mean that they are unable to experience themselves and the world around them? that they are unable to experience anxiety?

For a long time, a sort of institutional defence appears to have operated in relation to the idea that very premature babies might indeed experience things. It is particularly apparent in the context of discussion about the management of potentially painful procedures, and also in relation to the very real debate about the ethics surrounding the preservation of life. Acceptance of the idea of an infant who in some way experiences what is happening to him or her has far-reaching implications for both infants and carers. The staff in the unit where I carried out most of my observations seemed to let me know this when it became apparent to them that I was actually interested in babies’ experiences. A colleague who had also observed infants in this situation told me that she had found it impossible to sit and observe without taking notes at the time. Her description of using her notepad and pen as a defence felt familiar. Nursing staff found it almost impossible to comprehend why I was doing what I was doing, and more than once passed comments like one made on the first day: 'It looks mad, just sitting there, watching.' Their questioning of my motives diminished over time, and I think that this was related to their changing perspective. It seemed that my presence had a similar effect to that described in the home setting,
where mothers are often felt to take more notice of the baby’s experience as a result of the observer’s presence.

This defence seems to operate at different levels, and in the face of an increasing body of research which provides evidence of premature babies’ behavioural and physiological responses to their environment. Gorski has proposed that these infants communicate their experience through their behaviour:

High-risk prematurely born infants exhibit behavioral responses that represent signals for neurophysiologic stability, disorganisation, or distress. These cues may precede less subtle, more costly physiologic crises that caregivers commonly recognise as calls for care-giver reaction. (Gorski 1983).

He gives an example of the importance of attending to the baby’s signals:

One nurse had been singularly effective in feeding this baby, no one else could get him to suck feeds from a bottle. She alone avoided the aspirates and the vomiting that predictably accompanied feedings. In watching and talking to her, I learned that she disliked the infant. All the other nurses were strongly attached to the baby, and, out of sadness and guilt, were trying harder and harder to act as normal parents to him. Whereas they provided as much contact and social stimulation as they could, this nurse clocked her obligatory ten minutes for feeding the infant while holding her hand away from the isolette, looking away from him. And the baby sucked and swallowed the entire bottle-full. The baby’s father taught me what he too noticed about his son. The infant would maintain eye-contact with him only so long as he held him at arm’s length. As soon as he held the baby close, the infant averted his gaze from his father’s face, increased his respiratory rate, had unstable skin-color changes and really looked distressed. (Gorski 1983).

Field (1990a) has very clearly demonstrated the relationship between potentially stressful procedures and physiological signs such as increased heart-rate, altered skin-tone and decreased oxygen tension. She has also demonstrated the potential soothing effects on these babies of gentle stroking and non-nutritive sucking, both of which seem to help the baby to hold itself together (Field 1990b). W E Freud (1989) has specifically commented on the latter, having noticed the dramatic effect of offering a very sick baby a finger to suck:

More than once he rallied dramatically: he sucked with amazing vigour and became temporarily far more alert and co-ordinated ...; his sucking was in the service of holding on.

Freud felt that the ‘uninterrupted presence’ of the baby’s mother ‘might have assured sufficient alertness for him not to give up and die’.

To return to the psychoanalytic literature, several authors have referred to the ways in which babies ‘hold on’. The mother’s holding over a period of time is the
main way by which the gradual move of most babies to a more integrated state is facilitated. However, Shuttleworth (1989), among others, has also drawn attention to the ways by which a baby might hold himself together. He might do this by focusing on some aspect of his inanimate environment or use his own bodily sensations, such as the tension in his muscles, to somehow hold himself together. Bick (1968) felt that a reliance on these latter methods might lead to pathological development. Winnicott's description of the mother's failure to adapt well enough to the infant leading to precocious development and ego-formation, and the creation of a False Self (1960) might also be related to the infant having to find something else to hold on to. A number of authors, for example Newman (1981), have observed premature babies apparently staring at one particular object, or pushing their limbs so hard against the side of the incubator that they turn white, perhaps also in the service of holding on.

All infants have periods when they are more together, that is, in a state of integration, and periods when they are falling apart, that is, either disintegrating or returning to an unintegrated state. These states are usually easily recognised by their mothers who ascribe meaning to particular aspects of the baby's behaviour. In doing this they are informed by what they see, hear or smell, and by what they feel. The screaming distressed infant is not only experienced out there, in its cot or in its mother's arms; it is also experienced inside the mother. Similarly, the contented, satisfied infant is experienced inside. This unconscious communication between infants and their mothers, and mothers and their infants, is replicated in the analytic session. In both settings the validity of the communication is accepted. Psychoanalytic infant observation also relies upon this unconscious communication, so that:

Emotion holds a cardinal place. It has to be observed and recorded and it will occur in the observer and the reader. It is not a distraction or a contaminant. Correctly grasped, the emotional factor is an indispensable tool to be used in the service of greater understanding (Miller 1989).

Infant observation may have something to contribute to our understanding of the early experiences of premature babies. However, it will be important to question the interpretation of the observed behaviour and so-called physiological 'communication' of these infants, and, in particular, the question must be asked whether it is as legitimate to make inferences from observations of very premature babies as it is from the study of older babies. With these reservations in mind, there are a number of questions which psychoanalytic infant observation might begin to help us to answer:

Are premature babies able to experience themselves and their world? If so, at which point is there a change, the change which Winnicott (1966) described by saying that 'to anatomy and physiology becomes added psychology'? Does that point represent the beginning of a primitive ego?
The answers to these questions have implications both for research and for clinical work, but cannot be considered without addressing the second theme of this paper, that is, reciprocity.

**Reciprocity**

The baby's sense of self develops in the context of the mother-child relationship, which for ordinary babies is almost taken for granted as the main influence on the baby's development. In Shuttleworth's words:

The mother's capacity to respond to her baby's experiences seems to be felt by the baby at first as a gathering together of his bodily sensations, engendering the beginnings of a sense of bodily integrity (Shuttleworth 1989).

Thus, 'in favourable circumstances', that is, if there is good-enough holding,

the psyche has come to live in the soma, and an individual psycho-somatic life has been initiated (Winnicott 1962).

The process by which meaningful interaction between infant and care-taker evolves is related both to the infant's contribution and to the care-taker's, and to each one's interpretation and fit with their partner's actions. The initial emphasis in this dialogue seems to be on the adult's contribution, and interpretation of and response to, what the infant brings. In Richards's words:

From early in foetal development, an infant's behaviour is patterned in both space and time. ... Adult caretakers recognise these patterns and assume that some of them provide indications of what is occurring inside the infant. ... By such recognition they confer the status of social interaction upon these behaviour patterns (Richards 1974).

Brazelton, Trevarthen, Murray and Stern have all contributed to an increased understanding of the nature of mother-infant reciprocity. Two papers in particular by Brazelton and his colleagues (1974 and 1975) describe the microanalysis of mother-child interaction in the laboratory situation leading to the identification of characteristics of the developing relationship. These included the mother's sensitivity to her baby's capacity for attention and non-attention, and her learning how her behaviours were interpreted by her baby; in particular, which of these behaviours set up an expectancy of interaction. The rhythmicity of interaction seemed to be as important, if not more important, in the development of their relationship than what the mother or the infant actually did. This having been said, it was noted that infants of three weeks not only responded with concern and distress if presented with a still-unresponsive face, but it was observed that they tried to draw their mother back into the interaction. Trevarthen (1977) reported similar findings, and also examined the way that the infant 'directed' the mother-child interaction (1974). Murray *et al.* (1993) have looked more specifically at the actual dialogue between mother and
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infant, and have noted the effect of maternal depression on the contributions of both participants and on the nature of the fit between mother and child. The specific research on the impact of depression on 'motherese', that is a mother's particular way of talking to and about her baby, is important for a number of reasons, not least of which is that it draws attention to a pathological process which may be amenable to therapy, in particular parent-infant psychotherapy.

In the special-care baby unit, the fit between mother and infant may be of paramount importance. These babies are likely to have to make do with less of their mother's holding. Instead, they have to make what use they can of nursing staff, and rely more than the average baby on themselves and their immediate environment. Further, their experience of their relationship with their mother might be less than ideal.

Things look different from the mother's point of view too. She does not just have to respond to her baby's overtures; she has a greater responsibility than the ordinary mother to initiate the interaction. And she often has to do this without being able to pick up and hold her infant; that is, she often has to engage the baby in some other way than by holding and positioning, and of course feeding. She is often deprived of a feeding relationship for several weeks, and during this time she may feel very unsure of how to communicate with her baby. She may also feel unsure about whether there is any point in trying, having little sense of what that experience might mean for the baby, or even whether he is going to live or die. The way in which she behaves at this time will be influenced by her relationship with staff and by her own mental state and belief system. To give two extreme examples of this: she may be very determined to get to know her infant and believe that she can call her baby into life; or she may feel she has no power to influence events at all. The way in which she behaves at this time will be influenced by her relationship with staff and by her own mental state and belief system. To give two extreme examples of this: she may be very determined to get to know her infant and believe that she can call her baby into life; or she may feel she has no power to influence events at all. One mother spoke of spending weeks at the cot-side singing to her daughter little songs which she had made up, while stroking her or simply holding her hand. This baby had been born at 25 weeks, after a precarious pregnancy, but survived remarkably intact nonetheless. Another baby born in similar circumstances had a mother who rarely visited. She seemed depressed, and also had not mourned the loss of a previous infant. She told me that there was nothing she could do, that her baby's fate was all in God's hands. Her visits testified to this belief. She sat motionless at the cot-side, only occasionally reaching in to touch her baby. This baby quietly lost her grip on life and died when her mother was abroad visiting her family.

Of course, it would be unwise to read too much into these two examples; but, to return to the theme of rapprochement, Alvarez's ideas about claiming or reclaiming in the context of psychotherapy provide a way of making one particular sort of sense of these stories. In her account of psychotherapy with an autistic boy, Alvarez (1992) has referred to

the rather passive implications of the function of containment, with its notions of thoughtful reverie, [which] 'seemed to leave something to be desired'.
Alvarez described her function as having to ‘reclaim’ him because he no longer knew how to make his own claims and later compared this with a mother’s role. Child development research on the origins of reciprocity not only describes the role of both mother and infant; it also focuses on the mother’s need to be sensitive to her infant’s communications. Alvarez has reminded us that the mother also has a more active part to play:

Apparently the normal mother permits and respects some degree of withdrawal on her baby’s part, but she also plays, however gently, an active part in drawing him into interaction with her (Alvarez 1992).

Descriptions of mothers with their new-born babies illustrate this active role more clearly, and can be described as ‘claiming’ rather than ‘reclaiming’. It is characterised by particular facial expressions and movements, and by ‘motherese’, a particular way of talking, described by Murray et al. (1993) among others.

**Observational Material**

**Daniel**

The following extract from observations of a baby born at 29 weeks by spontaneous breech delivery illustrates what has been said.

Daniel was the second child of Mrs D, an Irish woman. This extract is from an observation when Daniel was ten days old.

Daniel is in an incubator. He is wearing a white baby-gro and has a tube in his nose for feeding. He is lying on his back with his eyes wide open; he has a shock of blond hair. I am immediately struck by how cherubic he looks, how like a real baby. He seems to look much older than some other infants I’ve the seen of the same gestation. His mother is very close, and has both hands inside the incubator. She hovers for a moment and then touches his arm gently. ‘I think he’s going to be sick’, she announces, to me I think, even though we haven’t even said hello. I’m surprised that she has noticed my presence.

She smiles welcomingly, but says again, ‘I think he’s going to be sick. Just a minute and I'll turn him over.’ She opens the incubator and turns him onto his side. She gently rubs his back, ‘It’s all right, it’s all right’, she says quietly. He looks at her (I think he’s looking at her) with his bright blue eyes. A nurse is nearby, and Mother tells her about the sick. Then he is a little sick — onto the sheet. ‘There — he’s done it, he’s been sick,’ she says, with a sense of relief and also satisfaction that she has known what was troubling her baby.

The nurse comes over. ‘Oh yes,’ she says, it’s very mucousy — better out than in.’ She sounds very business-like and matter-of-fact. She says that she will give him some suction, and leaves. Mother continues to gently rub Daniel’s back and croon
to him. We look at him together. With this mother, I do not feel as if I’m intruding; she seems very proud of him and seems to give me a message that it’s all right for me to join her in her adoration.

I comment on what lovely hair he has, and she agrees. ‘It’s really blond.’ He is lying on a slight slope in the incubator; she strokes his head. He has a green teddy with a shamrock next to his head, and there are two or three other cuddlies, including a green dinosaur, at his feet. His incubator is like a little nursery; I feel he is already Irish. He looks alert and calm.

The nurse returns, and I fetch a chair and sit down. The nurse is busy sorting things out, disconnecting and reconnecting wires, and moving him. She leaves him on his back. His hands are held out. One is held up in the air. He moves his fingers slowly, very slowly, flexing and extending them. His other hand is caught under a wire. He’s making all these movements with one hand, and the other one feels as if it’s got stuck. I want to say something about it. He seems to want to move this other one, but he can’t. She comes back and opens up the front again; the mother is standing watching. ‘I’ll just put some suction on his tube.’ She does this, and finishes with him, and then moves away again. She doesn’t actually say any more. I’m fascinated — have they had a previous conversation: or is there some sort of understanding because of a previous occasion or routine? This mother seems to have a way of knowing.

A bit later, the nurse brings a chair for Mother, and when she’s sitting she gives her a blanket, and then lifts Daniel out onto her lap. Mum is just delighted and she smiles, beams at him. He looks up with his eyes wide open. She wraps him in the blanket, leaving room for his hand to reach out. She holds his hand with a finger of her free hand and jiggles it a bit. ‘He’s got quite a grip for his size, you know,’ she says proudly. She looks very proud. She looks at him. I feel they are very together, very calm.

A few more minutes pass. She is watching him; he is watching her. She holds his hand or strokes the back of his hand. And then he gives three huge slow yawns: ‘O-o-oh, you’re a tired little baby,’ she says. ‘Are you a tired little baby? Oh-o-o-oh, or is it just so-o-o boring?’ He gives two short abrupt sneezes and his whole body shakes. He is all snuggled up in a blanket. I can just see his head and his little hand outside the blanket. After a few wriggles he is still again. Quiet. They seem very peaceful.

This mother seems to be in tune with her baby; the couple are a pleasure to observe. The mother focuses on the baby with her gaze, her touch and her voice. She lets him know that she is there and she is attending to him. Her gaze is there to meet his when he is ready, and he seems to take up this offer despite his prematurity. Her voice talks to him, and about him, and has a musical quality. She ascribes her baby potency or agency, and is clearly bursting with pride, even though he has arrived early. She empathises with him, to the extent that she knows he is going to
be sick. This empathy does not result in distress; it helps her to comfort him, and although she remains calm throughout, she is in no way detached.

Her communication with the nurse is interesting. They do not speak much to each other but are clearly in tune. I say this more because of what the relationship feels like than what can be objectively evidenced. This mother feels as if she is being looked after, emotionally contained by the nurse.

This baby seems to me to be in a state of alert inactivity. He is not jittery; nor is he withdrawing into sleep. His togetherness is likely to be partly attributable to his mother's holding, but also seems to me to represent more than that. He seems even at this young age, the equivalent of thirty weeks' gestation, to show some pre-adaptation, a readiness to meet the world. He seems to be aware of his separateness, and I wonder if this can be interpreted as a sign of early ego-differentiation.

Brian

The second example is of a mother and baby who are not getting on so well. Brian was also born at 29 weeks, after a pregnancy characterised by bleeding from very early on. In my first observation, I had spent a long time watching his mother gently trying to rouse him, without any great success, and she had seemed to interpret his reluctance as a rejection. In this extract from an observation at sixteen days she has just learned that he is likely to have a learning disability. She also tells me that she started bottle-feeding him the day before.

Mother brings the bottle, puts it down, and lifts him out, talking to him quietly as she does so. She puts him on her lap and tries to lift his head up with one hand. He opens his eyes. She rubs the teat of the bottle gently on his lips. It is huge compared with him, and she comments on this, saying that it is the smallest size, and it just doesn't seem right. She encourages him to open his mouth; then strokes his throat, telling me that this is the way to get them to swallow. The nurses have told her this — it encourages them to drink. There is a feeling that she believes that this is a bit cruel, and I notice that she has to separate herself and her baby from the theory about babies in general.

It's all very difficult. I feel she has been very calm, but now she gets a pit panicky about it. She tells me how important it is for him to take it. He's got to put on weight. She persists more calmly again, stroking his throat and pushing the nipple into his tiny mouth. His heart-rate drops suddenly and the alarm goes off. There is no apparent change in the baby, who seems to be lying peacefully with his eyes mostly shut, but opening every twenty seconds or so for a few seconds. It's difficult to look at him and the monitor simultaneously. A nurse comes rushing up and tells the mother that it's too much for him; she should give him a rest. His heart-rate quickly returns to normal, but from now on Mother watched the monitor and not the baby while she's feeding. She feels blamed and I'm not surprised. She says she doesn't know what to do: watching the monitor means that it is more difficult to fee him — she needs to concentrate on him to feed him. From the way she talks,
it is clear that this has happened before. Then she tells me that he was on some medicine to keep his heart-rate up, but they have tried without it for the last day. Another nurse comes with some medicine. They've decided to resume it. She gives it to him via his nasogastric tube. She is very warm and sympathetic, and clearly tells the mother that it was not her fault that his heart-rate dropped. This reassurance is kindly given, but somehow doesn't undo what's already been said.

This extract illustrates a number of points. My sense is that Brian's mother has been stunned by the news of his possible disability. I guess that some mention has probably been made of the importance of nutrition, and thus the sense of desperation as she tries to feed him. She has to distance herself from her sense of her own cruelty, and refers to what the nurses say about them, other babies perhaps, as she forces the huge nipple into his mouth. Up until now this baby has given his mother little reward for her, at times heroic, efforts to engage him, and this has distressed her. She tries to remain calm, but cannot do so.

The two nurses' reactions to the temporary crisis are at odds, and with the first there is no sense of support or reciprocity. This has on the whole been this mother's experience of the staff, and also their experience of her. She feels criticised, and they have found it difficult not to be critical of her. Her relationship with her own mother seems to have been an important influence on this dynamic.

Alan

The mother in that example draws attention to a particular difficulty encountered by a number of parents, and that is whether to relate to the baby or the monitor. This is further illustrated in the next piece of observational material, which related to a very fragile infant attached to even more equipment than usual.

Alan's mother looks agitated, and seems not to be able to be still. She stands with her back to the baby, facing the monitor and her partner. She still has her hand in the cot beside her. She seems transfixed by the monitor, and they are talking quietly and earnestly. The partner moves over to look at the charts; she does so too. She presses some buttons on the machine and continues to watch it. She glances occasionally at Alan, who is lying mostly still and calm. He occasionally wriggles and reaches his hand up to his tube as if to pull it out. Then he is still again. He doesn't open his eyes.

Mother suddenly starts to rub his chest; then bangs it, six quick slaps in rapid succession. She is not looking at the baby, but at the monitor. Again: rub—rub, bang—bang. Mum and Dad both look worried. She takes her hand out of the cot and fiddles with the machine again; then puts it back on the baby's chest, gently this time. She quietly pats him and watches the monitor.

Dad tells me that the reading is supposed to be more than 90. I continue to watch them watching the monitor. Alan is quiet and still, seemingly oblivious to all this, his ventilator pumping away. His mother in particular is glued to the monitor and
responds to every swing with vigorous rubbing or banging on his chest. His heart-rate and oxygen-saturation levels are not stable. The latter goes down to 64-70-68 — frequently. I feel worried.

Later, when they had left, I noticed that his saturation levels remained very steady, occasionally reaching 94, and I found myself wondering if this reciprocity with the machine instead of with the baby, and enormous anxiety on the mother’s part particularly, had in fact pushed this baby into a more vulnerable position. Afterwards I thought even more about this. Was it possible that the mother had transmitted her anxiety to her baby? She certainly transmitted it to me. Instead of bringing him back towards a steady physiological state, did her actions actually knock him further off balance? Field’s (1990a) research shows a very clear relationship between stressful procedures and oxygen tension. This baby may have been feeling very stressed by his mother’s state.

Baby observation, and baby observation in a neonatal intensive-care unit in particular, arouses emotions which at times feel overwhelming. There is not only a sense of the baby’s struggle, but also a real sense of helplessness, aroused, I think, by identification with both the baby and the mother. Sometimes it feels as if these mothers are faced with an impossible job to do. Indeed, the task of mothering a special-care baby is so difficult to think about that professionals have perhaps come to realise that there is no right distance or right way to do it.

That is not to say that there are not things that we can do to help the relationship get off to a good start. Mental-health professionals working in special-care baby units approach their task in different ways. One way, which has been described by a number of child psychotherapists (Szur et al. 1981), is to help both parents and staff focus on the baby’s experience, and thus draw them into a more sensitive relationship with the infants. The observational method provides a foundation for this kind of work, and is a crucial aid to understanding.

CONCLUSION

Special-care babies to a greater extent than other babies are in a very real life-or-death situation. We do not really know what they are experiencing while professionals battle to save their lives. Nor do we really know whether their emotional states or their relationships affect their outcome. However, staff are often perplexed by the realisation that some babies survive against the odds while others appear to surrender life more easily. While not necessarily easy to apply to premature babies, Klein’s ideas about the baby’s internal struggle may help us to make sense of these observations. The increasing evidence of full-term infants’ pre-adaptivity or readiness to relate to their objects seems to confirm the existence of an early ego, while Piontelli’s work gives some insight into the processes going on prior to birth. Observation of premature babies may further contribute to an understanding of the baby’s early emotional life, not only by describing the infants’ states, but also by examining their early relationships. By this route it may be possible to identify the characteristics of early
relationships which are most likely to help the baby to grow and develop, and more importantly, to survive.

My own observations suggest that the fit between mother and child is of paramount importance. In the absence of the *in-utero* environment, which provides one sort of nurturing and preparation for a life which begins at about 40 weeks' gestation, a mother's role is not just that of the ordinary good-enough mother. She has to do more. It seems likely that some premature babies may need to be 'claimed' or called into life and into a relationship in the face of overwhelming anxieties and very real external threats to their existence.

**REFERENCES**


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