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A place where verbalisation has no meaning

Nara Amália Caron, Rita Sobreira Lopes* and Tagma Schneider Donelli

This paper, which is based on observations of women in labour in the obstetric centre of a public hospital, describes the challenges for mothers, as well as for the observer, who enters the ‘sacred place’, a place where verbalisation has no meaning. We hope to show that perhaps the greatest challenge for the observer is to reconnect with the helplessness which accompanies human beings from the beginning to the end of life. In childbirth, we suggest, the experience of both physical and emotional regression psychically challenges most women to the limit. The paper draws on previous experience of applying Bick’s infant observation method and on Winnicott’s theory of primitive emotional development. The paper assumes that the mother’s primitive psychic and physical experiences during labour and delivery reflect a state of regression which develops during pregnancy and continues for some time after delivery. This is assumed to enable the mother to connect with her baby and his state of helplessness.

Keywords: observations of women in labour; delivery; regression; Winnicott; Bick; primitive emotional experience; mutuality

Introduction

It will be observed that I am taking you to a place where verbalization has no meaning. What connection can there be, then, between all of this and psychoanalysis, which has been built on the process of verbal interpretations of verbalized thoughts and ideas? (Winnicott, 1968/1988a, p. 92)

This is how Winnicott, in his article, ‘The mother-infant experience of mutuality’, invites us to enter the ‘sacred’ place. He goes on to write, ‘...it is as if a work of art were being subjected to an analytic process’ and he asks himself,

Can one be sure that the capacity to appreciate this work of art fully will not be destroyed by the searchlight that is played upon the picture? It could indeed be well argued that these very early phenomena ought to be left alone, and I, who have found myself making a study of them, could not but insist that what we think we know about

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these intimacies, is not useful reading material for artists, or for young mothers. The sort of thing that can be discussed when we look at these early phenomena cannot be taught. (Winnicott, 1969/1989, p. 251)

Winnicott gave a lot of careful thought to the study of early psychic phenomena. He was concerned not to interfere in them, and proceeded with caution, but he saw, in the subtleties of the mother–infant relationship, a great opportunity to learn about human nature, ‘...we shall be caught up in the immense needs of the dependent infant and, in the countertransference, with the massive responsive processes which show us, to some extent, what is happening to parents when they have a child’ (Winnicott, 1969/1989, p. 252).

Through the contact with the baby and the mother, he also saw the opportunity to learn about psychotic pathology and about psychoanalytic technique with these patients,

...from schizoid patients, we can learn to observe mothers and infants, seeing more clearly what is found there. But essentially, however, it is from the mothers and the babies that we learn about the needs of psychotic patients or patients in psychotic phases. (Winnicott, 1968/1988a, p. 101)

Winnicott’s contemporary, Esther Bick, also saw the enormous learning potential that the observation of the mother–infant relationship can provide both to psychoanalytic training and the investigation of early psychic phenomena. She not only invites us to enter this place, but she offers us a method for observing the phenomena found there. She also believed that we had a lot to learn from mothers and infants, but not to teach them. Furthermore, like Winnicott, she was concerned not to interfere with the mother–infant relationship, and the method she devised is very specific about training the observer not to interfere.

Our research group has applied and extended the Bick method of infant observation, into observations of pregnancy, childbirth and prematurity. In our work, we have found, not surprisingly, that the challenges for mothers and for the observer are even greater. These primitive stages reveal human fragility and helplessness, and the total dependence on another for existence. The baby is the image of helplessness and powerfully evokes a number of different emotional reactions. In a previous paper, we have shown the intensity of these reactions during pregnancy through observations of the foetus in utero, using ultrasound (Caron, Fonseca, & Lopes, 2008). The new mother–foetus dyad is filled with the fact of absolute and mutual dependence; the foetus on the mother and the mother on the foetus. At any time something can go wrong for the baby or in the intrauterine environment and either the baby or the mother might not survive.

At the point of childbirth mother and infant have already gone through an important developmental stage, pregnancy, but they are still faced with life and death challenges and the helplessness and mutual dependence that characterised the previous period. In addition, both mother and baby have both experienced
the enormous discontinuity which occurs at birth: the baby moves from the uterine environment to the world outside the mother’s womb. He will now need to be held in his mother’s arms and will have to negotiate separateness. Discontinuities such as this will be present in other developmental stages, but never with such a degree of intensity as at childbirth.

Childbirth is one of the greatest moments of helplessness, if not the greatest, not only experienced by the baby, whose immaturity means he/she is totally dependent on his/her mother, but also by the mother, who finds herself in a state of regression. It is less common to explore the maternal experience of childbirth. In his paper on the birth experience, Winnicott (1949/1992) gives us a clue to thinking about the mother’s experience in labour, which we find helpful. ‘There comes a state in labour in which, in health, a mother has to be able to resign herself to a process almost exactly comparable to the infant’s experience at the same time’ (p. 184). More recent psychoanalytic research on the perinatal period, especially pregnancy, has stressed the emotional impact of the baby on its caregivers, arousing primitive feelings and anxieties (Caron, Fonseca, & Lopes, 2008; Raphael-Leff, 2000).

It is frightening, even terrifying, to recognise that the baby is totally dependent on the mother, who simultaneously experiences states of helplessness herself. However, it is precisely this condition of physical and emotional regression which Winnicott (1956/1992) called primary maternal preoccupation that makes women able to identify and empathise with the baby and thus be able to welcome him and take care of him. One might say that childbirth is a paradoxical moment of mutual and utmost helplessness for both mother and infant.

Both Winnicott and Bick described the infant’s initial state of non-integration, where the mother’s presence is essential for the infant to experience a feeling of integration, of being held together, of not falling to pieces. For Winnicott, it is through the maternal holding that this becomes possible. Esther Bick describes the mother’s primary containing function as that of creating a primary skin function to hold the baby together (Bick, 1968). She also shows the difference between non-integration as a passive experience of utter helplessness, and disintegration, through the processes of splitting, as a defensive operation to the service of development. For Bick, at birth, the baby is like, ‘...an astronaut in space without a spacesuit’ (Bick, 1986, p. 296). In this state, the baby is subject to catastrophic anxieties, equivalent to the unthinkable anxieties described by Winnicott (1968/1988a, p. 98) – fear of falling forever, going to pieces, psyche and soma divided, complete isolation because there is no means for communication. In her regressed state of identification with the infant the mother reconnects with this initial state and she herself may be subject to the same primitive infant anxieties; for Bick, the mother also loses her spacesuit at moments.

We now move on to some vignettes taken from observations in an obstetric centre over 19 months. The written reports were made after each observation and presented to the seminar group, for discussion, according to Bick’s method. We intend to illustrate and even more, try to take the reader with us to this
‘sacred place’ through our attempts to translate into words what was experienced during the observations. (For a discussion on the challenges of translating into words such primitive, nonverbal experience, see Caron, Lopes, Steibel, & Donelli, 2012.) Although the observations were done in a public hospital, we shall illustrate the emotional experience of women during labour, which is experienced in a solitary and private way, in her own body, independent of the environment where she is, whether in the presence or absence of a companion.

The application of the Bick method to a context so different from the usual home environment, the hospital, relies on observers who have already undertaken an observation of a baby in his family, at home, as originally described by Bick, as one of the essential experiences for the training of future clinicians (Bick, 1964). This application, however, was based on the same epistemological principles as the standard method. Despite the different context and the diversity of situations and people, the observational setting was maintained consistently in day, time, place of observation, the same professional team and weekly observation seminar groups. All observations were done by one observer for one hour each time in the pre-delivery room. Even though observations were generally fixed at one hour, whenever possible, the observer accompanied the women to the delivery room, and the duration of the observation sessions at that time were extended.

The observer’s initial experience in the obstetric centre
In the first contacts with the obstetric centre, the observer described it as intimidating, frightening and embarrassing,

I managed to cross the room, but at the insistence of the nurse, who wanted to show me where the delivery rooms were. I was, half-embarrassed, thinking that I should be wearing different, hospital clothing, or perhaps that I should stay still so as not to feel I might be disturbing something.

It seemed to be inevitable that the observer would allow herself to feel taken over by feelings of insecurity, confusion or lack of preparation. Everything seemed very different from what is usually expected to find:

(…) We went through the way most women do when they go to the obstetric centre. They go to Reception, where they are seen and directed (…) to the examination room. They are asked to go through a wide door which gives access to the interior of the hospital, which is restricted. It is like entering another world.

The corridors had many turns, without clear signposts to tell people where they were or directions to tell them where to go.

You find yourself against a tiled wall (…), and you have to turn left and go down the hall. At the end you need to turn left again. There is a poster with a picture of a stork with a big arrow on it pointing to ‘Maternity’. Passing the sign, the hallway gets darker
(….) there is only a small window and a door at the beginning (…) with a bell saying ‘Knock and wait’. But that is not the entrance for the women in labour, it is just a ‘service’ entrance for hospital staff. You pass two more unidentified doors, and the third one is the examination room door, with a very discreet bell.

The reports made it clear that it was not an easy task to keep looking; at times there were dramatic events and the possibility of death. There were times of despair in the face of physical and emotional pain and of the imminent event of birth, as well as the experience of enormous demand for emotional care. There was rawness, an overexposure to all of this that disarmed the observer. The obstetric centre seemed like a place where people got closer to something they were trying to cover up; something that revealed more than they would have liked; something that went beyond intimacy to soul-bearing, highlighting primitive fears and anxieties. The contradiction of it all, the mixed messages, disarmed and depressed everyone:

The whole time I have the impression that things were scattered around, despite knowing, rationally, that everything has an explanation. I think it begins at the entrance, where the posters conceal a precarious, caged, tight, smelly environment. There is no privacy at all, quite the contrary, there is overexposure, and that bothers me a lot. The women seem to feel extremely displaced, abandoned, alone. I leave wanting to stay longer and, who knows, to see more while simultaneously it is a great relief to breathe fresh air and to be in a more spacious environment. And I get a very clear impression: that it won’t be easy…

After the first observation, the observer could see how the emotional climate, generated by the chaotic and unwelcoming environment, would require quite a commitment as well as emotional investment in order to carry out the work:

I started coming back, coming the opposite way, trying to get back to the examination room and to the newborn admissions, but always staying close to the nurse, because I could not imagine myself there alone. Where would I be in the next observations? Would I be able to sit down? Which way could I look?

**Primitive anxieties and emotional expression**

Issues related to the female body were described in practically all observation report, and they surpass all the emotion which is also present. Words and symbols gave way to concrete expressions of pain, disgust, anxiety and shame, and all are shared by the observer. The proximity with the primitive is frightening, and even something familiar to everyone, like defecation, vomiting and bleeding, seems to provoke the need to ignore them or to hide them away.

Despite being natural, these human bodily experiences are constantly denied and hidden in social life. But there, the smells and colours would mix to form a screen full of details that could have never been seen in this way in any other environment. In some reports there were references to blood, ‘There were only
two patients there (in the labour room). There were some unmade beds and a bed with blood spots on it’ (. . .).

I went in and (. . .) (the nurse) was just telling me to take care, because everything was full of blood. I realised there was blood spattered on the wall, and a little more on the floor, but the way the nurse spoke to me gave me the impression that I was going into a minefield.

In other reports, the observer refers to vomiting.

I went to the pre-partum ward and found Anita assisting Joana, who was vomiting. Giovanna was beside her, and the vomit hit her. Anita waited to help her go to the bathroom to wash; Anita held the rubbish bin for Joana as she apologised to Giovanna for getting her dirty.

The physiological aspects of childbirth, such as the pace of contraction and the progression of dilation of the cervix, evoke feelings of losing a piece of oneself with fear of surrendering to the process and losing one’s reference points. These experiences resemble the infant’s unthinkable anxieties, still not integrated and with no environment that contains him and them. Such experiences may be responsible for attempts by the women in labour to exert some control over the process of the baby’s birth or of using other means, mechanisms, mental or physical to protect themselves from the invasion of extremely powerful feelings. This need for control seems to be experienced by women in an intensive way, spanning the entire labour and delivery itself. The lack of control over the whole process of the baby’s birth seems to cause great anxiety in patients:

The doctor came to examine the patient and when he lifted the blanket, he said she had emptied her bowels. The smell filled the room and the patient seemed very embarrassed. The doctor examined her and said she had dilated 6 cm. He asked for one of the assistants to clean Caren because she had defecated. (. . .) Caren went back to bed and while sitting, she defecated again; she did seem not to have any control over her bowels.

The doctor came, put on gloves, and found she had dilated to 7 cm already. At least Caren knew the baby was not coming out of her without any control, like her feces. She gave me the impression that she did not want to let the baby be born. She seemed to be closing her legs, trying to hold him inside.
Labour and delivery carry the risk of transforming into a traumatic situation for women, since they are forced to deal with feelings of loss and separation from the baby in the womb. It is possible to witness women’s expressions about the “missing” belly soon after birth, like a concrete loss of a part of herself:

...at any given time, to the surprise of all who were there, Claudia exclaimed, almost frightened, that she no longer had a belly just after the obstetrician removed the placenta and showed it to her. (...) Claudia felt her belly and then lifted up her cover to look at herself.

Another woman showed from the stretch marks on her belly, the numerous marks that a pregnancy and childbirth can leave:

Anne practically did not move. Occasionally, she would rub her own stomach and would sigh. From my position, I could see the numerous red stretch marks in her belly which seemed to have been forced to stretch under all that weight and volume.

It must be made clear that, here, we are not only concerned with the physical stretch marks on the body, but the marks left on the mind and soul of these women. The marks left in a woman’s life by the birth of a child are undeniable, but to witness those left on the body lead, undeniably and in a more dramatic way, to thinking of the emotional impact. These are both the marks of something good and developmental and those which stand as a barrier to the women’s emotional growth. When she allows herself to be touched by the experience, she will most certainly be changed, with different psychic structures from before the pregnancy and birth.

Another common aspect of the women in the maternity ward was described in the reports as alienation. This appeared to us to be a kind of altered state of consciousness that would make the women feel foreign to their surroundings, so they would interact only minimally with the environment, they would speak little and would even sleep during the process of labour. This state, in our view, can be an indicator of women’s deep regression and of their predominant attunement, during labour, with their inner emotional experience. In some situations, it was possible to understand what looked like obliviousness or indifference as a defence against the primitive anxieties, sensations and feelings which they might have been experiencing. In a particular situation, we observed a particular pattern of behaviour when a pregnant woman was about to give birth to an extremely premature baby of little more than 26 weeks’ gestation. ‘Sabrina seemed totally oblivious of what was about to happen to her; that she would give birth to a baby very early, that she would face the hospitalization of the baby and all the risks of prematurity’.

It was not always in high-risk situations for mother or baby or both that some women showed signs of feeling alienated. This is important, because the experience of alienation can, in our view, also be a manifestation of the primitive,
nameless, intense feelings, which are required in order to identify and empathise with the baby:

There were four patients there, all very quiet, as if they were asleep. (…) they were very shy, all with their eyes closed, and I didn’t want to bother them. (…) Julia remained facing the wall, lying down almost the entire time. I could see her face for just one moment when she sat up to turn sideways. She had beautiful features, but her face was a mystery; she had the face of a woman, but at the same time she looked like a young girl. She saw me standing there, and smiled before lying down again and disappearing. She made me think of the sea, and how these women seem to dive into an endless ocean, surfacing for a few moments, perhaps to show that they are still there. In fact, we know they are there, but we do not really know where they go.

In a sense, it was also very common to see women sleeping during labour, ‘A pregnant woman with twins arrived (…) a much physically abused maltreated woman, aged 39; she looked 90. (…) she was almost 9 cm dilated, but did not complain of pain. When I left ward, she was sleeping peacefully’.

We note with interest that there seemed to be alienation during birth itself, both in one normal birth:

(she) seemed a bit oblivious to everything, and did everything she was asked to do. She spent quite some time on the delivery table, until the baby was born. The doctor seemed very calm, and was explaining everything to her: anaesthesia, episiotomy, the strength of anaesthetic (for a caesarean section) … Cintia arrived, and [the anaesthetist] began to explain the anaesthesia procedures. Cintia seemed to have already been sedated. She did not question anything nor show any reaction, she seemed far away from everything. It was as if everything was happening to someone else.

Labour pain was another common experience observed. Like any other pain, it has biological, social and physiological elements, and it is also subjectively a unique experience. The way each woman expresses her pain seems to have a close relationship with her personal character, with her subjective need for care, with her level of confidence, and in her own capacity to endure pain and her capacity to experience becoming a mother. Numerous expressions of pain were observed during the study. Most of them were linked to the evolution of labour, to the increased intensity of the contractions and the decreasing interval between them, and also to the reality of not knowing for how long they would have to endure the pain, confirming their belief that that suffering would be endless and intolerable. This experience could be perceived as a threat to the integrity of the woman and to her own life; it would be like being stuck in a dead end without the ability to manage the situation.

There were also observations of the women’s reactions to feelings of fear, helplessness, suffering, exhaustion during and after labour, and the
observer was the witness, strongly in identification with the woman (or the baby) observed:

The hours did not pass and I was getting tired. There was no place to sit and I started walking from one side to the other, trying to be as discreet as possible. This time, I realised even more clearly how narrow the pre-partum room was. You could hear all the noises from the hallway as well as from the street and the hospital car park entrance. People came in and out and the three of us in there were in a world completely apart. Even time seemed different.

I changed places and went to the other side of the room. Sandra was exhausted, and so was I. I felt hungry and thirsty, and it seemed that I would never feel myself again, Sandra looked at me several times, smiling without saying a word.

Many of the women in labour seemed to communicate their loneliness and helplessness to the observer – through verbal, but mainly non-verbal communication – not just for establishing connection with someone, but as a way it seemed of communicating fears and anxieties.

And, suddenly, it was just me and Sandra in that room, which was very, very large. I stood there where I was, and Sandra was asking for help. What could I do? At one point, she looked back and saw I was still there. She turned back to the wall and begun to stammer that she did not want to be left alone. I wanted to say that she was not alone but I was sure it wouldn’t help. She was alone, and all that she was experiencing was very lonely. I was there and decided to stay until the delivery. It was what I could do.

Such feelings were evident especially after childbirth, when most women were left alone in the delivery room. The mother loses her partner, the baby, and the baby also loses his partner, the mother. They are in similar states of helplessness and loneliness:

The obstetrician completed the delivery very quickly and soon the nurses tidied up everything. Suddenly, it was just me and Lea in the room. (…) There was movement in the room and suddenly everyone was leaving, they were disappearing, and all the movement seemed strange like an invasion followed by abandonment – at least that is how I felt it. I stood there with Lea, and she kept talking to me, interspersing conversation and silence.

This makes one think how women are really alone as they confront the birth of a child. Although they are in a hospital, surrounded by professionals, equipment, technology and materials, the whole process of birth is experienced in mother’s own body, in a solitary and private way.

Some contributions of childbirth observation to a psychoanalytic understanding of primitive emotional development

Undertaking weekly observations in an obstetric centre for a period of 19 months was a unique experience. On many occasions, the observer wondered
what made her carry on with experiences which mobilised such anxiety, tension and discomfort, as observing childbirth. Carrying out observation in an obstetric centre provides the opportunity for the observer to connect with and experience something exciting, moving but also something nameless which is so primitive that it cannot yet be expressed verbally or have meaning. Moreover, it was very gratifying to let oneself be used by the mothers, to develop an empathic capacity, and an identification with the women. One is also able to go beyond physical holding and care to offer a kind of emotional holding similar to maternal function. To be together, to listen, to welcome and to share, uncritically the unconscious experiences of a woman in labour, are aspects of the observation which, in our view, are themselves therapeutic and mostly welcomed at this challenging moment in a woman’s life. Both the women and the observer profited by the experience which felt increasingly meaningful as the weeks passed. It is clear to us how much an observer can modify and enrich herself with such an experience.

We hope we have conveyed the challenges for the mothers as well as for the observer from entering into that ‘sacred place’ where verbalisation has no meaning. The observer immerses herself in the observation and is thrown into a world of sensations, emotions and primitive anxieties that impact in different ways. She is exposed, like the women in the pre-delivery and delivery room, and at the mercy of intense and unspoken feelings.

Through the observer we can understand Winnicott’s suggestion, in his paper entitled ‘Environmental health in infancy’, that ‘…the main things that a mother does with the baby cannot be done through words’ (Winnicott, 1968/1988b, p. 61). The intense, silent psychic activity required by the mother during early development should not be trivialised. There is a parallel, we believe, in the observer’s silent, mental activity. In Bick’s method of observation, and in parallel with psychoanalytic technique with regressed patients, as Winnicott suggested (1992c), the setting becomes more important than interpretation. Bick (1968) also emphasised the importance of the setting for patients in analysis who had not been able to form a primary psychic skin. She wrote, ‘It must be stressed that the containing aspect of the analytic situation results especially in the setting and is therefore an area where firmness of technique is crucial’ (p. 486).

During labour, it is assumed that women become very sensitive to professionals’ attitudes, especially to their nonverbal messages of tenderness, acceptance or disapproval. However, it is very difficult for professionals to attune themselves to this primitive level of communication and to give birth to their own feelings of helplessness. Instead of just being there with the women, they think they must do something. Consequently, women are often left alone to rely on their own resources (Raphael-Leff, 1996).

It is very demanding for the observer and the mother to connect with that primitive level of psychic functioning, just as Winnicott said that it would be demanding for the analyst to work with regressed, psychotic patients. He wrote that he could only manage to work with one or two patients in that state of mind at any one time. He commented on the treatment of one of his patients:
... the treatment and managing of this case has called on everything that I possess as a human being, as a psychoanalyst and as a paediatrician. I have had to (experience) personal growth in the course of this treatment which was painful and which I would gladly have avoided. In particular I have had to learn to examine my own technique whenever difficulties arose, and it has always turned out, in the dozen or so resistance phases, that the cause was in a countertransference phenomenon which necessitated further self-analysis in the analyst. (Winnicott, 1954/1992, p. 280)

We can say that, although the duration of labour and delivery is short, it is an intense experience and has the potential for emotional overload and for being able to disrupt, usually only temporarily, the women’s sense, during labour, of going on being. Helplessness was perceived in many women entering into a strange, frightening space, defying death and madness. To experience the physical and emotional regression that occurs at birth is really a challenge to the limits for most women as well as in their capacity to move through different levels within the structure of their own minds and internal worlds.

Drawing on our experience of applying the Bick method to primitive stages of development and drawing on Winnicott’s theory of primitive emotional development, we assume that the primitive anxieties, sensations and reactions observed both in mothers and the observer during labour and delivery are expressions of a regressed state of mind which has already begun to develop during pregnancy. We also assume that this is what enables the mother to reconnect with her own helplessness and which prepares her to find the baby where he is, in his state of helplessness.

To abandon oneself to this state of ‘normal madness’ is healthy and necessary, but not easy. In his paper entitled ‘This feminism’, Winnicott (1964/1986) argues about the risk of childbirth. ‘It is no good pretending that childbirth carries no risk...there is a danger in the woman’s natural function’ (p. 193). And he goes on to say that not only is it not easy to go through childbirth but also to go through ‘...the whole confinement and the terribly restricting responsibilities of infant care’ (p. 193).

It is therefore not difficult to understand why many women are unable to achieve this state of mind, this identification with the baby and who may experience him instead, at least for a while, as a foreign body whose expulsion she awaits in order to feel relieved and quickly to return to her previous condition of life. Such women go through the whole process without experiencing it, a situation that complicates the possibility of mother and baby immersing themselves in an experience of mutuality and for both to emerge transformed by it. The infant’s self emerges, necessarily, from within that mother/infant unit.

The mother needs to be healthy enough to be in touch with her helplessness and resigned to it. We conclude with a quotation from Winnicott (1968/1988a) which shows how the mother’s reconnection with the state of helplessness is
inevitable and essential in order to meet the baby’s helplessness at an exact moment to identify with him:

Certainly there is something that happens to people when they are confronted with the helplessness that is supposed to characterize the baby... We could almost say that those who are in the position of caring for a baby are as helpless as the baby can be said to be. Perhaps there can be a battle of helplessness. (p. 102)

Notes

1. The vignettes have been taken from the third author’s doctoral thesis. The first author was the seminar leader and supervisor of the observations and the second author was the academic supervisor of the third author.

2. The seminar group membership was as follows: the seminar leader, the obstetric centre observer and two other observers applying the method in two different contexts; one was observation in a large family (Vivian, Lopes, & Caron, 2011), and the second was an observation of an infant with Down’s syndrome (Oliveira-Menegotto, Lopes & Caron, 2010).

References


