When the internal setting becomes more important than the therapist/analyst's interpretative capacity: extending the infant observation method to the prenatal and perinatal period

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The authors continuing work over several years with Esther Bick’s method of infant observation has created a strong sense of its usefulness as a tool for developing the capacity to ‘listen’ with increasing refinement to primitive psychic phenomena – as well as developing the receptive and containing capacity of professionals trained in observation. These capacities are essential for dealing with primitive transference/countertransference phenomena where the analyst’s internal setting, her consistency, reliability, constancy and preoccupation is more important than her ability to interpret or her theoretical knowledge. The authors have begun to apply the method in longitudinal observational studies of obstetric ultrasound examinations, from the 12th week of gestation, up to delivery. The paper includes a brief case illustration of how the trained professional’s internal setting, enriched by the original infant observation experience, may facilitate developmental processes, especially integration, during the delicate period of gestation, further helping parents to prepare for delivery with all its inherent anxieties.

**Keywords:** pregnancy; delivery; observation of ultrasounds; internal setting; perinatal period; prenatal period

The infant observation method created by Esther Bick provides a unique opportunity to delve deep into the human soul, have direct contact with the first baby experiences and interactions with his/her mother and with the most

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primitive experiences in his/her natural environment, the family, a privileged emotional space for healthy or pathological development in the early years.

However, it is worth remembering that before the baby can be observed at home, the mother–infant couple must have experienced two vital developmental stages: pregnancy and delivery. After a lot of time teaching infant observation and using it in specific settings, we began to use the model in the ultrasound setting, visiting the baby in his/her first home, the maternal womb (Caron, 2000; Caron & Fonseca, 2011; Caron, Fonseca, & Kompinsky, 2000; Caron, Fonseca, & Lopes, 2008; Caron & Maltz, 1994). More recently, we have also done applied observations in the obstetric centre observing the delicate and sometimes dangerous moment of transition when the baby leaves the maternal womb to be born and held in his/her mother’s arms, with all its inherent anxieties (Caron, Lopes, & Donelli, 2013). Considering that sometimes the baby is born prematurely, and mother and baby are suddenly ‘displaced’ and have to live in the impersonal environment of a neonatal intensive care unit we have also supervised observation in this external setting (Moreira et al., 2011; Steibel, Caron, & Lopes, 2014).

After more than 25 years’ experience with the Bick method of infant observation and its applications we feel able to say that the observer’s capacity to ‘listen’ with increasing refinement to primitive psychic phenomena, and the development of a refined receptive and containing capacity, is the shared thread. The trained professional takes with her an internal setting, enriched by the original infant observation experience, and is able to adapt herself to the external settings where the method is applied.

As in the standard method, the trained professional takes part in the experience as a participant observer, stripped of her usual theoretical and therapeutic tools, relying on a certain kind of emptying of the mind and emotional availability, she assumes an eminently receptive state through which she accepts the baby’s and parents’ non-verbal communication and is deeply involved in the live dynamics observed. The professional trained in infant observation is better equipped to deal with the major challenge of the first moment of observation when there is an intense internal mobilisation caused by the impact of the live experience of the mother–infant dyad. The observer is thrown into a world of sensations, strong emotions and primitive anxieties which manifest themselves in different ways and to differing degrees according to the observer’s personal history and character. Listening involves all senses. The presence of a baby stimulates regression to primitive states of mind and to communication through the body, which, in our view, generates intense and wordless emotional experiences and physical sensations in the sensitive observer. The trained observer is receptive, discreet, attentive, delicate and respectful and she has an effective non-verbalised part to play. In other words, she is in the process without needing to take on an active role as therapist, advisor or judge.
while her mind and body continue to be extremely active in processing what is seen and felt, partly at an unconscious level.

The significant experience in ordinary infant observation promotes changes in the participants, as many trained professionals will testify; they feel a greater sensitisation to non-verbal communication, an increased reliance on intuition, a stimulus to the feelings and the imagination, greater contact with their own psychic reality and that of their patients. Their clinical work is transformed and they often say that they are more reflective before formulating interpretations. Having struggled with one’s own resistances, the emotions and experiences can be used as a tool for paying greater attention to the countertransference and its meaning. The Bick method has proved to be particularly useful and facilitating of the development of new theoretical and technical thinking, the development of more questions and as a stimulus to research. It is an excellent training for simultaneously sustaining the predictability of the setting while maintaining internal flexibility, so important for the mother–infant couple at the earliest post-natal developmental stage.

Winnicott (1956) argues that at the most primitive level, in which dependence is a fact, the mother who is able to regress and empathise with her baby:

provides a setting for the infant’s constitution to begin to make itself evident, for the developmental tendencies to start to unfold, and for the infant to experience spontaneous movement and become the owner of the sensations that are appropriate to this early phase of life. (Winnicott, 1956, p. 303)

This very early setting was valued by Winnicott in his clinical work and was the basis for an original theory of technique which expanded the concept of transference to include dependence in various stages of infant and childcare. In these situations, Winnicott maintains that communication is predominantly direct and non-verbal; he warns about the risk of premature, invasive interpretations. Working on this primitive level is something that is very demanding on the analyst and implies a countertransference in which the therapist experiences some processes very similar to mothers who take care of their babies.

It is likely that the therapist or analyst’s consistency, reliability, constancy and preoccupation, the internal setting are more important than his or her interpretative capacity and theoretical knowledge. Even though it was not our initial purpose, the usefulness of infant observation as a tool for training these capacities in analysts and psychotherapists became increasingly evident to us. Such capacities can then be applied in early interventions to help parents and their babies therapeutically. For instance, in the obstetric ultrasound setting we feel the trained professional’s presence facilitates emotional expression, and it allows children, parents and other family members to express anxieties, hatreds, rivalry, love and desires. It also enables the fulfilment of the fantasy of returning
to the womb or being able to look inside it, which brings with it intense fears and anxieties of being trapped or of becoming an unwanted intruder, along with much remorse and guilt. Children more easily express these fantasies than adults, who also have them but do not readily dare to admit it. The children get inside their mothers and place themselves side by side with their siblings in utero, and this is expressed either through their behaviour, play or drawings.¹

A 5 year old girl accompanies her mother during an ultrasound examination (34 weeks of gestation). She is talkative and friendly. She asks a lot of questions. She is curious about the measurements of the space and the size of the fetus and uterus. When she offers her drawing she says she wants to talk to the doctor. She explains, naturally, that the biggest image is herself and the smallest is her brother. They are both in a house which has two doors. She is very worried about the size of the doors. The largest orange one is for her to come out and the smallest, which is pink, is for her brother. The doors are closed and she does not know who will come out first or what will happen if the doors do not open.

This free emotional expression is facilitated by a receptive and containing setting, in which the staff and the child share a creative game. The child creates something that is already there and it is neither inside nor outside the mother’s womb. In this situation, the child exercises her magical omnipotence, creating the illusion of a sibling who is introduced, drawn, accepted and who can also be discarded and left in the examination room:

A 3 year old girl remains seated on her father’s lap during the whole examination. She tried hard to hold her father’s face turned towards her so as not to look at the fetus. At
the end of the examination, she seems relieved, holds her father’s hands and leaves the room happily. Before leaving, she looks back at the monitor and says with a happy and triumphant smile on her face: ‘Bye, bye, baby!’.

In a similar way, in a previous paper (Caron et al., 2013), we have suggested that to remain together, to listen, to welcome and to share uncritically the unconscious experiences of a woman in labour are aspects of the observation of labour which, in our view, are themselves therapeutic and mostly welcomed at a challenging moment in a woman’s life. The trained professional is also able to go beyond physical containment and care to offer emotional containment similar to the 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.

It is worth remembering that when Esther Bick wrote about the infant observation method she highlighted its therapeutic potential (Bick, 1964). She noted with surprise how it was easier than expected to find mothers who were willing to accept the observer in their homes and how they made it explicitly clear that they very much enjoyed and appreciated the observer’s regular visits.

We shall go on to present observational material illustrating the extension of the method to pregnancy and delivery aiming to show the great opportunity it offers for us to learn not only about early psychic phenomena, but also about the basic principles of the therapeutic work in this place ‘where verbalization has no meaning’ (Winnicott, 1988, p. 92), keeping in mind that it is the mother–infant couple who can teach them to us.

Longitudinal observation of pregnancy until delivery: a case illustration

Many years ago we set up observations of obstetric ultrasound in a Brazilian clinic for several years always with the same doctor. Both in situations of foetal pathology (Caron & Maltz, 1994) and normality (Caron et al., 2000), our initial studies were developed out of our curiosity about prenatal life, especially the mother–foetus relationship, with its complex conscious and unconscious psychic processes. These studies were largely inspired by Piontelli’s (1992) pioneering work with obstetric ultrasound.

We have witnessed many changes and developments through the years. There has been a technological evolution in obstetric ultrasound examination, and we have observed social changes including more often the presence of fathers, siblings, grandmothers and even great grandmothers. At the beginning, mothers would come alone, the emotional climate was of intimacy, ‘almost a secret’.

Relying on some trained professionals’ written reports, we conducted a joint analysis of the observation of the participants in the examination (Caron et al., 2008) and found that as a result of the intense internal, individual mobilisation in response to the image and the setting, all participants seem to have a reaction
which favours regression and which tends to encourage more sensitivity and open expression of sensations and feelings of helplessness, loneliness, vulnerability, ambivalence and rivalry.

After conducting many individual observations in the ultrasound setting, over more than five years, we made a first longitudinal observation throughout a pregnancy all the way to the delivery. A book has recently been published with the results of these observations which were followed up by standard home observations every week until the third year of the baby’s life (Caron & Lopes, 2014).

In the following brief case report summary we aim to illustrate the richness of the extension of the Bick method to the prenatal and perinatal period and its therapeutic implications. At this point we had observed eight obstetric ultrasounds from the 12th week of gestation to an observation of the baby’s delivery.

**Virginia and Horacio – singular pregnancy: Marina**

**The gestational period**

The first meeting with the couple was at the first ultrasound examination. Virginia is a woman with pretty features, always smiling, strong, determined and always willing to mediate the reactions and behaviour of her husband, as if to excuse him for his lack of control and to rebalance the relationship. Horacio seems a little strange; he looks somehow undefined. He is restless, agitated, changing position all the time, sighing. His mouth is half open and he stutters a bit when he speaks. He seems frightened, uncomfortable.

In a very open and authentic way, he confesses his fears and concerns after the first ultrasound scan. He says he is a mechanic, ‘The environment is difficult, Doctor, … I am very worried, very nervous; I get home and then I have to spend some time outside to calm down before going. I sit there and play with the dogs to calm down. And now, she’s like this (pregnant) I’m very concerned, very anxious […] my work is very hard, I think I cannot attend the scans. I came today because I’m on leave’.

The couple had experienced a miscarriage four years earlier near the third month of pregnancy. At the time, Virginia said she felt ‘guilty’ because she thought, ‘I lost the baby, because I was very anxious, I could not put my hand on my belly; I was not caring, I did not want the pregnancy’. She thinks it is good to have this assistance from the observer, ‘This special care’. Although married for 16 years, ‘I did not feel I was ready to have a child’. She says she is now ‘happy because I’m pregnant, I think it’ll work out, I’m always putting my hand on my belly, caressing it […]’ and she determines, ‘It’s a girl! Everybody wants a girl!! Her grandfather will love her, he’s only got grandsons and Horacio also wants a girl!!’. Horacio says: ‘Hmm … It can be a girl … A girl is alright … I’m very worried, very anxious’. Virginia often interrupts her husband with a speech, maintained until the last scan, ‘Horacio is like this, so nervy, but he is a very
good man, he was a very good son to his mother, I’m sure he will be a very good father too … we have to find the balance’.

The word ‘balance’ was used a lot by Virginia during the ultrasound scans. From the beginning it seemed clear that her strength and determination were dependent on Horacio’s being ‘nervous’ or anxious feeling underevaluated, incompetent, aggressive. This couple’s interaction begins to be defined and determined during the scans. It is a fundamental pattern in maintaining the delicate balance of both, now threatened by the presence of this stranger, uncontrollable and unknown – the baby.

The father was present at all scans as the observer suggested. He hardly looked at the baby’s images on display, but he would watch the observer, as if only through her could he see the baby. The 13th week of pregnancy illustrates these points:

The Doctor asks Horacio to pay attention to the image, ‘Look there, upside down’
Mother smiles, always attentive to the screen. She closes her hands, as if she was hoping for something, thrusting.
Father looks very quickly at the baby’s image. He frowns, squeezing his face, runs his hand across his face, he peeps at the image and looks at the observer.
The observer asks if he can see the baby.
Father whispers, ‘Hm, hm,’ and continues to look at the observer.
The observer looks at the baby on the screen.
Father looks at the image slowly, saying, ‘I thought it was dark, woe, woe, woe’, looking at the observer, rubbing his eyes as if he wants to open them.
The doctor says, ‘Dark? No, the darkest area is the liquid, the baby is here,’ pointing with her hand at the dark place on the monitor.
Father says, ‘No, yes, now I can see Doctor. Thank God, woe, woe, woe,’ sighing and always looking at the observer.
Mother says, ‘It is just that he is very worried. We lost the baby the other time, now he is like this, so very worried, very nervous’.

Throughout the scans, when identifying the baby as a girl, mother begins to identify similarities between the baby and the husband, like the nose, legs, the way she puts her hand on her head, and predicts that she will be, ‘Worried like the father’. During the scans, the baby transmitted through the images, according to the radiographer, that she seemed to be a ‘very calm baby, who likes to sleep’. The baby’s movements are peaceful, gradually unfolding from 13 weeks when she starts to do the swallowing movement, opening and closing of the mouth, sticking her little tongue out, taking it in and ‘tasting’ as the doctor says. She also appears to be lying on the bottom of the mother’s womb with her legs bent slightly upwards and little hands on her head, as if sitting,
'anchored' in mother’s belly. In this position, she makes a slight body swing, giving the impression of owning the space. In one of the scans, mother is able to relax and places herself on the examination table in the same position as the baby, giving the observer the impression that by looking at the mother she would see the baby, as if they were merged and just one.

They are in the same position. There is a sense of satisfaction from both. The baby with open arms, swallowing, and her mother, too, lying, with open arms, smiling and looking at the baby. (34 weeks)

Meanwhile Father sighs, sweats, says he is hungry, wants to leave:

Doctor, I am hungry, everyone is hungry, it is noon already, it is time, you know how it is, the tummy is asking for food … it has to be faster. There has to be time for lunch, you could give us a hand, can you be a little bit faster there?

In another scan, the baby is sleeping and so is the father, his legs stretched forward, his hands on his belly, his head leaning to one side. The observer writes that when baby opens her little mouth the father yawns. When the doctor asks if he can see the baby he suddenly wakes up. The baby also wakes up and starts to swallow in her usual way, ‘tasting’ and she goes back to sleep. Everybody looks at baby Marina, admiring her beauty and gracefulness. During the pregnancy, Virginia demonstrates a great need omnipotently to control both the foetus’s development and her husband’s feelings and attitudes in order to be able to keep the couple’s ‘balance’.

Virginia and Horacio enjoy the observer’s support, containment and patience during this transition to parenthood that they have both fiercely wanted and feared. The father benefits particularly from the observer, who allows herself be invaded and her mind penetrated by him, as he guardedly keeps her in his gaze. She allows herself be used as an emotional drain, a receiver to relieve him from his fears, anxieties and aggression evacuated into her. Proceeding in her role, the observer enables Horacio to be more present in the observations. At the end of the scan he exclaims, ‘Thank God! Well, now we can have our little talk?’ which is a short meeting for the couple with the observer, in which she listens to questions, clarifies some doubts and schedules the next scan. Horacio likes and enjoys this space.

The last ultrasound is a harbinger of the turmoil that will set in with the birth of Marina and the loss of control and hormonal, physical and psychological ‘balance’ that Virginia has feared so much. Horacio arrives seeming to feel cornered; he has lost his house keys for the second time. Virginia complains strongly, leading us to think that she feels threatened by the serious risk of overflow of what she has herself projected into Horacio. After many provocations she would stare at him and say, as usual: ‘Give her a smile, aren’t you going to give her a smile?’ He leaves the last observation session without saying goodbye, expressing the threat of rupture, ‘lost keys’, that pervaded this pregnancy.
Delivery

Demonstrating how much Virginia relies on and trusts the observer, Silvia, Virginia’s sister-in-law, calls the observer to let her know that Virginia is already in the hospital and that, ‘She would not stop saying that I had to let you know, that was all she talked about’. When the observer enters the Obstetric Centre, she sees Virginia who says: ‘Well, this naughty girl has decided she no longer wants to stay inside her mother’s belly. She wants everyone to know who Marina is’. Virginia expresses in this way how much Marina challenges her in her command and control now she is born. Virginia feels a lot of pain, and the obstetrician gives her some advice while she firmly holds the observer’s hand.

Horacio is in a room watching TV, distracted. The already familiar sequence, to try and keep Horacio close to where things are happening, begins. It is interesting how everyone there tries to help him to go into the delivery room because Virginia is requesting his presence.

He smiles, runs his hand across his head, face, he sweats, he sighs, he says, ‘Oh my, oh my.’ He looks at me, shakes his head saying, ‘No, no, no,’ Then, ‘Yes, yes.’ The Doctor asks if he is afraid and Horacio replies, ‘What if I faint? ‘you will stay there lying on the floor’, says the doctor. Everybody laughs, and Horacio says, ‘Ok I’m going’. His sister gets all excited. After a whole ritual Horacio comes in smiling. He quickly comes near Virginia and says: ‘Virginia, this is it’. He makes a cheering gesture with his hands.

He chooses a place to sit and says, ‘I’ll sit here!’ (by the observer’s side). He crosses his legs mimicking her position, tapping his fingers on the arm of the chair. He has the attitude he had during the scans. He looks up, sideways and sometimes at the observer. ‘When I look at him he looks away […],’ she writes. ‘He crosses his hands, says something softly, I can’t understand what it is’. The observer gets up, and stands near the door. He goes to her side. He seems to be her shadow.

She explains to the father that he could stay ‘on this side of the curtain’ and he soon feels relieved: ‘I’m going to stay on this side of this curtain. Oh, so it’s much easier than I thought. It’s simple’. So this is how the story goes:

In the delivery room Horacio sits near to Virginia’s head, remaining there all the time, talking to her and gently stroking her head. I only listen to what they say at a time when they speak loudly and Horacio repeats that the dogs are his children, just as Virginia has said. They are waiting for Marina so then can play together. They will love Marina. Virginia agrees with him.

Marina is coming out calmly, lying on her mother’s legs. She cries very loudly and looks very healthy. Still connected to the umbilical cord, she is calm and quiet, while the obstetric assistant aspirates her mouth; she cries a little more, as if she is complaining because she’s been bothered. She is described as, ‘A perfect girl, beautiful; a painting. She has a lot of hair, she is chubby, she looks very big’.

While Horacio refuses to take Marina to the nursery, Virginia says in a determined voice she wants to breastfeed the baby while she is still in the delivery room. Marina, lying with her face sideways, on her mother’s breast, begins to make the same movement with her mouth that she made when she was in her mother’s womb. It seems as if the observer is seeing the same baby she observed in the ultrasonic scans. She pushes her little tongue out, licking her lips; then she swallows, appearing to be savouring something. She lays her face sideways in her mother’s chest again, sleeping.

The observer thinks, ‘It is a victory! This baby will go to look for what she wants’. Virginia and Horacio watch her sleeping, stroking her face, her little head, kissing her. After a few minutes, Marina wakes up, apparently wanting to be nursed, looking for and licking the nipple then swallowing.

**Final considerations**

Until a few decades ago, the mother–foetus world was totally private and unexplored. This fantastic world in which the new human being develops, unique and singular, would need to be observed at the time of delivery in order to check the expectations and desires of the mother, father, other family members and physicians.

Today, with the latest ultrasound scanners, we follow the foetus’ behavioural details, reactions and even sensations in the intrauterine space. To be able to enter in this ‘sacred place’, the female womb, to uncover its ancient mysterious contents and to get answers to many and old questions seems to be one of the fascinations of contemporary humanity.

Biotechnology has been pushing the notion of human omnipotence and awakening the most primitive phantasies. Obstetric ultrasound is an example of how much contact with the foetal universe has changed. Yet, in spite of all these technological changes, it is important to remember that human nature has not changed. It is very challenging to enter the intrauterine space, to experience its darkness and to discover the life that unfolds there, sequestered from the external world. The trained observer-professional is able to enter this space more easily relying on the capacities developed in infant observation training, especially her containing and receptive capacity, which are very helpful for parents so that they can allow themselves to be more openly in contact with this world.

Obstetric ultrasound has become a routine examination in our environment and is a unique opportunity to see how the foetus lives with relative autonomy and skills. A pregnant woman is there, lying down, with more than the abdomen exposed, covered with a viscous gel. Bare abdomen exposed inside. Everyone is looking in. Nobody leaves the room or moves around.

The presentation of an ultrasound image is never neutral. The impact is also due to the immense quantity of information available through these images presented all at once to our perception. It is as if a dream suddenly were
condensed and real in one image, bringing to life in each participant some primitive psychic content.

There are multiple layers of pregnancy experience – simultaneous births; passages to another stage: from daughter to mother, from son to father, from an only child to sibling, from mother to grandmother that provokes modifications in each one’s psychic structure. Primitive experiences emerge more easily to consciousness, making the prenatal period a space for the past to reappear, to be revised and elaborated on, but also a challenge to the psychic structure.

The examination allows for a quick, direct access to the intrauterine space in the external setting of the examination room which is relatively dark, silent and intimate, with closed doors and windows – a reality which feels separate from outside. Perhaps, therefore we can say that the setting facilitates emotional experience, especially when there is an observer whose own internal setting or framework is receptive to it, and contains it for them.

It is not unusual to see fathers or other family members who come with the pregnant mother competing with the foetus in a variety of ways for space, love and seeking to be noticed. We think that Horacio, for instance, used the observation space to express very freely his massive identification and competition with the foetus. He would very spontaneously communicate his fears concerning the risk of returning and getting lost in the darkness of the intrauterine space. During an ultrasound scan, one is inevitably faced with the maternal power to give life or take it away. Horacio seemed to feel fearful and sometimes happily surprised to see life unfolding in the same space where he had witnessed foetal death before.

It is important to emphasise the medical doctor’s natural therapeutic function in the ultrasound setting. Through her, we developed a very clear idea of some challenges that are imposed on the health professional who comes into contact with very primitive psychic phenomena linked to early life. These phenomena require very similar qualities to those that a new mother needs with her baby. They are authenticity, openness and the capacity to be touched by primitive projection. The same doctor performs all the ultrasound scans in our research project, and we were impressed by her responsive, flexible but firm position. She allowed herself to be used by the parents and to share very powerful unconscious communications. We note here that she is a doctor who has had a lot of experience over time of ultrasound research with the same team. This certainly promoted some transformations in her work, increasing her understanding and consequently, her permeability and receptivity to unconscious communications which emerge more easily in this period of life. Interpreting the images with clear and objective explanations, respecting the pace of each one, she helped to ease the tension and alleviate the possible traumatic effect of the baby’s images on the family members. She would naturally adapt the setting to meet the needs of each father and mother. In Marina’s case, for example, it was very remarkable how the doctor, probably perceiving the mother’s feelings as the baby grew in the uterus,
beyond her control, did not mention the baby’s weight or length during the scans. The first reference to the weight only appears in the seventh observation, the 34th week of gestation following a comment from mother who said she had had a Doppler scan in the hospital because her glucose was high and she was gaining too much weight.

It was very obvious how Virginia and Horacio actively wanted the observer’s support, perhaps more intensely during the delivery, when the observer took mother by the hand and held her back, stayed with father to the gown room and introduced him to the environment he seemed to experience as hostile, helping him to step into the anteroom of that world that he so dreaded in the ultrasound. In continuity with the gestational period, the observer provided a receptive and containing setting which helped to reduce the emotional disruptive impact of the delivery on this sensitive couple. The emotional overload was reduced and she was able to support the mother’s sense of going on being. Her continuous presence had an important therapeutic, integrating function, similar to the maternal function.

We feel that some very rich aspects of early emotional life and interaction have emerged from these observations as applications of the Bick method in the prenatal and perinatal period. The trained professional is in an eminently receptive and tolerant state of mind. She acts as an ‘anxiety sponge’ which absorbs and then carries away with her all that is undesirable and difficult to digest. The seminar group helps her to understand and make sense of the raw and concrete experiences. In the observation described, one could say that Virginia would relieve her anxieties projecting them into Horacio, who would relieve his own anxieties projecting them into the observer who would carry them away to the seminar group. The observer could then get back into role more easily. The fact that the observer is a complete stranger to the family and different from other relatives is very important: she does not give an opinion or offer advice or treatment. She is an outsider, often eagerly awaited, a competent person, with another perspective, a participant observer who absorbs and digests silently. Her coming and going, opening emotional ‘windows’, helps to ventilate and detoxify the environment, reduces the sense and the reality of confinement in this early stage of dependence, alleviates the impact of sudden changes created by the baby’s presence. She provides a lively, receptive mental space which helps to develop trust, integration and the growth of the parent–baby relationship.

Note
1. In a previous study (Caron & Fonseca, 2011), around 75 children were asked to draw their siblings after the ultrasound examination which they attended.

References


