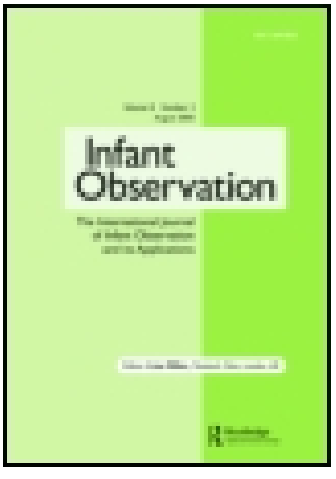

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Hilda Botero & Crispina Sanders
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Mother–baby relationship: a loving nest for mental health – observing 'kangaroo' infants

Hilda Botero*

Translated by Crispina Sanders

The Mother–Baby Kangaroo method used in Colombia is described with extracts from 'participant observations' of the author. It is suggested that this method of constant skin-to-skin contact between mother and baby, where the baby is sufficiently healthy to be able to breathe independently and to feed from the breast, and where mother has support, allows the baby to complete the gestation period and to continue to develop in an external extension of life in the womb. The author links her work in the programme with Bion's concept of container-contained, extending it to the idea of the risk to emotional survival becoming a risk to the container-contained function.

Keywords: prematurity; mother–baby relationship; Kangaroo Mother–Baby programme; container-contained; infant observation; applied observation in NICU

Introduction

A premature birth brings to view a mother–baby couple's shared mental state, where emotional survival is in danger as is the container-contained function which I suggest should be represented like this: (♀♂)![1] Some observations of these dyads in Colombian hospitals and in the Bogotá 'Mother–Kangaroo Baby programme' will serve to illustrate this representation of love, not between a man and a woman, but between a mother and her baby, confirming it as the basis for the baby's survival. The author suggests that this is not only physically important, but that it enables healthy, loving bonds to develop between mother and baby because they do not suffer the consequences of premature and abrupt separation.

*Email: hildabotero@hotmail.com

Prematurity

In observing these premature babies and feeling the urgency to defend this skin-to-skin union of the mother and her premature baby, I shall look at birth as beginning not when we normally consider it does, but at the moment of conception. When do we start to think about the existence of the human psyche with movements and connexions, as embryo, as foetus? This question needs an answer which we are trying to develop based on the experience of *here* and *now*, and on scientific knowledge. This is the approach of this article.

The defencelessness of the young human mammal is clear. At 21 months, having come into the world some 12 months before, a baby's chances of survival reach a healthy peak. But at the time of birth, nine months after conception, the baby is extraordinarily immature; gestation *in utero* is complete but, in my view, it is still imperative not to separate the baby from his mother once he is in the extra-uterine world. In the case of a premature baby, a different kind of knowledge, understanding and attention is needed to turn that particular situation into one which offers the best chances of establishing healthy and loving bonds. The mother of a premature baby is herself a premature mother who needs to have her maternal role confirmed and strengthened by the containment of others. The basic pillars of bonding (cell memory, procedural memory, the unconscious) have gradually formed in the womb. The unconscious begins to fill out slowly with experiences which are lived through. Premature babies go through very painful experiences not only because they are premature but also because they are subjected to a heart-rending separation; and if that were not enough they arrive in a world of isolation outside the womb that held them and they often undergo painful, intrusive interventions and tests. This raises the question of the link between their experiences of extra-uterine life, often not held by their mother and under the impact of the interventions which are done in order to keep them alive, on the form that their unconscious will take and what will be taken and develop in their minds as a result.

Thus, assuming psychic existence and emotionality in the baby relatively soon after conception, I consider prematurity as the visible representation of a mental state which is shared by the unit mother–baby. Perhaps anxiety that has been pushed aside, or psychic events that have not been investigated, lead to the configuration of a somato-psychic phenomenon (see for example, Bion, 1948, pp. 85–87, 1976–1992, pp. 242–244) where primitive mental life is manifested in bodily processes. In this primitive state, soma and psyche are not differentiated, and neither are mother and baby. Some elements which would later be seen as psychic phenomena are experienced physically. We cannot talk of observation, thought and judgement but rather of movements of the personality that lead to thinking with the body. The possibility of failure in the container-contained function (♀♂) – (mother–baby) is inevitable; physical and emotional survival is at risk and the container-contained function must now be seen as container-contained in danger, like this: (♀♂)! The field is invaded by the

unwanted intensity of the emotional turbulence. The process of catastrophic change: crossing over the birth caesura, i.e. the birth, is interrupted and a catastrophe rather than catastrophic change (Bion, 1966) may happen.

From this moment on events are conclusive and prematurity brings up an even more dramatic and dangerous condition for this dyad, separation. The baby is taken to the incubator and the mother is not carrying or holding her child. A better form of preparation or of bringing forward the reunion of mother–baby would be a positive contribution in this situation. The emotional and potentially catastrophic moment can be contained and directed towards a later transformation, adapting the minds of mother and baby for mutual recognition, through close contact, skin-to-skin, in a favourable atmosphere for emotional growth.

It is important to understand that premature babies are not ill babies[2] per se; they have rather gone through a premature 'transition' in their habitat. They become ill because they are separated from their mother-habitat. This stress is the origin of the illness. They are not ready to live in air, to breathe, to be fed, nor even to be held. Their physical and emotional postnatal life which would normally start through nursing and being wrapped and held as they adjust to the world is thrown into disorder.

There is worldwide scientific evidence of the potential as well as the limitations of the Kangaroo Baby–Mother method for mothers and their premature babies. The document *Scientific evidence of the benefits of the kangaroo mother method* produced by the Colombian Kangaroo Foundation in collaboration with the Ministry for Social Protection, Social Action, UNICEF and the PMA (World Food Programme) within the frame of the 233 Technical and Financial Aid Agreement of 2009 (Services contract – NFI No. 18/2009) acknowledges and supports it.

Origins of the Kangaroo Baby–Mother programme

The programme is the fortunate result of imitating, as a model, the final part of gestation in some marsupials. In these animals, the characteristic pattern is that the final period of gestation of their young takes place in an external pouch called the marsupium.

In 1978, the Clínica Materno Infantil of Bogotá, Colombia, was faced with the urgent need to look after premature babies with limited equipment and space. There was a great risk of infection and the heightened risk of medical complications arising from having several babies in one incubator. Dr Edgar Rey Sanabria, together with Dr Héctor Martínez Gómez and Dr Luis Navarrete Pérez, had the idea of using mothers as living incubators. The idea was put forward that instead of keeping mothers and babies apart, in order to economise on time, equipment and space and still use the appropriate resources, mothers could carry their babies, skin-to-skin between their breasts, like kangaroo mothers do with their young to ensure the success of the final period of gestation. So, at the hospital, mothers started to hold their baby skin-to-skin

between their breasts where the baby remained most of the time and, wherever possible, was fed by mother. As this began to work, the Kangaroo Baby–mother method was established as a programme for the care of premature babies in other hospitals, where it became known as 'Premature Kangaroo'.

In 1994 *the* Kangaroo Baby–mother method was used in a Day Clinic Kangaroo Baby–Mother programme led by Dr Nathalie Charpak and Dr Zita de Calume in Bogotá in its own premises, where it known as 'The Little Kangaroo House'. The method, having been recognised in Colombia, spread to other parts of the world. Professionals from different countries began to be trained in it, and now teams of medical staff, paramedics and psychologists have a training programme for the task.

In the Kangaroo Baby–Mother programme in day clinics the baby is held close to the mother's breast, or that of another adult, just like a kangaroo, 24 hours a day until it has reached the end of the gestation period. The mother is required to sleep practically sitting up and to hold the baby in position against her chest. This gives the baby the opportunity to continue in a position which is close to that of pregnancy, and mother offers her own metabolic rhythm to the baby to allow him to reach the term of normal gestation. What she provides, foremost, is warmth, food and protection; and most importantly, the method avoids prolonged separation of mother and baby. The baby is placed resting on his tummy, upright against the mother's chest like a little frog stuck to her body, between her breasts, alternating right and left cheeks, skin-to-skin, in direct contact. These dyads are looked after in communal wards where the mothers can share their emotional experiences, observe and compare their babies and the growth and progress of their premature babies.

Premature babies weighing less than 2 kg at birth or born at less than 37 weeks gestation can be carried 'in kangaroo'. In order to be in the Day Clinic Kangaroo Baby–Mother programme certain requirements must be met. These include satisfactory coordination in the baby's sucking, swallowing and breathing, and no serious pathology. In Bogotá a baby's need for oxygen is not an obstacle. Other requirements are indispensable for the mother and the family. A single mother cannot go into the programme even if she is willing and the baby's condition is acceptable. This is because at least one other person is needed to help mother when she needs to rest, or see to her personal care, take a shower, express milk and so forth. All this must be taken on board by the mother and the person helping her. Before enrolling in the programme, families are warned of their obligations and the risks and difficulties in the method. Only if they are mentally prepared and can demonstrate they have the basic ability to do the task can they enter the programme. A period of adaptation is necessary during which the mother receives instruction. As well as training, and in order to protect the emotional link throughout the gestation, the baby–mother interaction is observed so as to notice any anomaly that might stand in the way of normal development using the technique.

When the mothers take their babies home they do not bathe them. Instead they rub a little oil on their bodies every day. For the duration of the kangaroo period (end of gestation time and/or ideal weight) the mothers attend the day clinic where the baby's weight, size and head perimeter measurements are taken, and a general medical check-up is carried out, together with a neurological examination (Infanib) and growth check (Griffiths). Thus every step of their growth is measured. The staff also look at mother's feeding technique, her willingness to breast feed and the personal support she has available.

Breast-feeding entails even more sacrifice during this time and is what makes mothers most anxious. Because of the characteristics of premature babies and mothers' own mental state there is a lot of self-searching. This seems closely linked to a feeling of failure to keep the babies to term, and the fear that they might also fail at breastfeeding The baby's body must not come out of the Kangaroo position to be fed because this will cause a drastic drop in temperature, the results of which are a high risk both to physical health and to successful feeding. The baby must remain skin-to-skin, held by a special band that secures him to the chest. Premature babies sleep more and so they have to be woken up for feeding every hour and a half during the day and every two hours at night.

The mother offers her container skin and self to protect her contained baby; she offers not just her physical breast but her whole body and a mental attitude of dedication as a constantly present object in order to perform a transforming function, to create a universe prepared for life and growth, the expanding baby–mother universe (♀♂)*n* (Bion, 1963–1980, p. 126). Her body gives her the opportunity to construct her 'containing mental skin' as well as the physical experience of contact so that the baby can have an experience which has some links with life *in utero*.

Along these lines I now want to consider a proposal by Dr Nils Bergman (2005) from the Mowbray Maternity Hospital in South Africa. For Dr Bergman the Kangaroo Baby–Mother method is the right practice and he stresses that the baby staying at the mother's breast is the way to restore the 'original paradigm': baby and mother together, allowing the natural link between baby and mother to grow. The baby must not be separated from the mother after birth. Dr Bergman puts forward the concept of 'habitat–niche' in order to preserve as much of that original paradigm as possible. Habitat: A place where an occupation takes place and behaviour can be expressed, it is a 'direction', it is 'home' and it is a reference to being because existence is dependent on the place we are in. Niche: points to the unfolding of basic biological needs; it refers to behaviour or to *being* in a specific way *somewhere*. The mother's habitat is her skin, her breast, her mind. The baby brings the list of needs that shape and prepare the niche. The father and the nursing staff in the intensive care unit (ICU) must provide the context in which mother and baby can perform their loving task. It is container-contained at work. In this way, if habitat and niche adapt to one another, a nest is created in order to take care of the premature human.

It is in the womb, the baby's habitat during gestation, that the full project for growth and survival is planned, because the lines generated by the baby and by the two organisms, mother and baby together, create the exactly fitting habitat–niche without separation and supplying four basic needs: oxygen, warmth, food and protection. Human milk, the natural food, also creates a kind of continuity with the gestation that went on in the womb. Breast-feeding creates the habitat–niche link and it also offers protection.

With the habitat comes the niche but without the niche there is no habitat; they are inextricably joined. It is the newborn and not the mother whose instinct urges on the sequence of links by arousing, in mother, the maternal reaction to respond to the needs of the infant. This sequence and the link are established during lactation and in the interaction of mutual sensorial stimuli. The kangaroo position in the Kangaroo Baby–Mother programme is a call to re-establish that original paradigm of mother and baby united, not separated. It is also vitally important to defend the loving 'field' marked out for the maternal breast-habitat which is the essence of human awakenings and promises of union. Baby and mother as one, skin-to-skin, with the nipple nearby, in the mouth and in the mind, display the precise and essential action where, emotionally, hormonally and neurologically, love is revealed as the vital drive of the species towards survival.

When the baby is separated from the mother the habitat–niche is destroyed. Instead of putting into action the feeding programme where the baby at the breast creates the opportunity to build a secure attachment, what occurs is more like a defence deactivating the natural feeding programme as well as the reproductive one. The organism is invaded by stress, and protest and despair can replace the secure base that the maternal breast provides. Hofer (in Kandel, 1999, p. 514) was able to show that three different aspects of the rat kitten's protest–despair responses were triggered by three different hidden regulators within the mother–infant interaction: loss of warmth, loss of food and loss of tactile stimulation. The Kangaroo Baby–Mother programme ensures that warmth, food and tactile stimulation continue for the premature or low weight baby in order to restore the original paradigm, to strengthen loving and secure links.

If, as I believe, we have a specific pre-condition for human development, one where the brain is full of reverberating emotions and creative dispositions towards growth, but which is dependent on the quality of the relationship and the physical experience which fosters it, then it makes sense to protect and look after the mother–premature infant dyad The contained dyad gives rise to a specific quality in the feeling and working of their emotional links and prepares both for a happier and healthier life. This is an emotional and physical health promotion programme which affords the baby his right to life. It is also a programme which fosters more successful emotional relationships between baby

and mother (and baby and others later on), and it provides a better opportunity for future generations.

Maternal love is a container that prepares the niche during gestation, and with trust in the good judgement of the community of humans that receives the young at birth, the scene is set for the immediate manifestation of the impulse from the baby to connect with the mother's breast. A hypersensitivity in the mother and a hyperawareness of her baby are the natural dispositions to respond well to the baby's demands. The mother's hypersensitivity must be respected to preserve her concentration, and her disposition, conscious and unconscious, so that falling in love with the baby can begin and grow.

Many aspects of our bodily function and our emotional conduct are shaped by social interaction. For example a baby who is not rocked, held and contained well enough develops stress as a reactive response and different biochemical patterns to those of a baby who is well contained. The brain itself is a social organ (Fonagy, Gergely, & Jurist, 2004). Our mind becomes apparent and our emotions are organised through emotional involvement with other minds, not in isolation. The organism of the human baby develops as a response to the input of other humans, and this depends, to a great extent, on the father and the mother as primary carers. This is a fact constantly validated and more and more valued:

> (This means that) … the unseen forces which shape our emotional responses through life, are not primarily our biological urges, but the patterns of emotional experience with other people, most powerfully set up in infancy. These patterns are not immutable but, like all habits, once established they are hard to break. (Gerhardt, 2004, p. 16)

If baby and mother are separated, if habitat and niche are not joined, a programme of defence for survival is set in motion, instead of one for growth and development. The contact at the breast, skin-to-skin, is the habitat that prepares the baby to look after itself. Once there the new born is able to survive with his own resources, his own niche.

Observing Kangaroo babies

My work with premature and kangaroo babies began in October 1996, and it was love at first sight. I got to know the Day Clinic Kangaroo Baby–Mother programme and I have worked there ever since. I started my observations as part of community care in the Little Kangaroo House working with 'kangaroo parents' to help them to express the way they felt, little by little. In a way I too was carrying these parents kangaroo-style through that difficult and delicate experience as they tried to live through and to digest what they were living through, their fears, their moments of despair and their feelings of guilt.

I observed Andrea, a little kangaroo baby, following the Bick method (Bick, 1964). It was an extraordinary experience in every way, and it still is. Learning never stops, I see new things every day, I think all the time about it. It is rich

material, not easy to express with words. However, there are two points I want to make in the limited space of this article. First, because of the responsibility towards the baby–mother couple as well as for ethical and technical reasons, the observer of kangaroo babies must be a trained psychotherapeutic professional as well as an observer. Intervention cannot be put off in critical moments either for mother or baby. Death is a permanent threat to this dyad. Second, to be close to such emotional intensity, fear and anxiety as well as to the emergence into life from unknown great depths, an open, containing mind is indispensable. The energy of life is overwhelming and unyielding, and as the fog lifts we are able to observe a transformation in feelings, testimony of the burgeoning tenacity that grows roots when an emotional link is formed.

My experience suggests that the premature baby, and the kangaroo baby, is deep down still living for a time inside the maternal uterus, constantly recreating it in a desire for unity and safety. And this makes the experience of being present at this struggle to come into the world, the world outside the uterus, inviting and threatening all at once, a marvellous and dramatic experience.

Andrea, a kangaroo baby

Andrea was born three days before 32 weeks gestation on the Ballard scale. Her gestation age was 30.5 weeks and her life in the uterus had been difficult. The pregnancy had been hidden, only acknowledged when preeclampsia was suddenly diagnosed. Andrea was born by Caesarean section; she had intrauterine growth restriction, her weight was 1.2 kg and she measured 39 cm. Her encephalic perimeter was 27 cm. She also had new born tachycardia, multi-factorial jaundice, was given oxygen for two days and received antireflux treatment. She stayed in hospital for eight days for treatment of her immediate medical problems. Her mother, Consuelo, was 32-years-old when Andrea was born. She had hidden the pregnancy because she was afraid of what her adoptive parents might do if they found out. There had been two previous pregnancies: the first baby had not survived preeclampsia and the second was carried to term, a healthy 7-year-old girl:

> Mother tells me that the baby has stomach trouble, 'She is constipated and cannot fill her nappy… She had a bad night, she was crying all the time as if something was hurting her,' and she imitates the expression on her baby's face, 'She was twisting herself about, and crying very loudly. I have just given her a few drops of passion flower fruit juice because that's what the doctor said I was to give her to loosen up her stomach… I hope she gets a good rest now'. The baby, who had been calm and asleep, begins to cry; from where I am observing I cannot see any movement, but now I see her contracting her whole body as it rests on mother's chest, then she starts to stretch out, quite suddenly, her head tenses up as well as her whole body… her crying remains on the same level.

5th observation: Andrea is 34 days (week 37 of gestation), her weight is 1.64 kg

It seems to me as if her body were a string getting taut and her crying were the sound coming out of that string, so much in tune with the baby's state that you could say that her crying is part of her body's movements. I really think she was woken up by pain; she is twisting about, tensing up and then stretching herself as if gathering up the pain to expel it (into the mother's breast) with her rigid body and her crying. She does this for a good while.

Mother tries to calm her by acting out with her expression the baby's state as she perceives it to be. She mimics the pain and energetic movement; she rubs her baby's back on top of the blanket as she says, 'Alright, my baby, I know, it hurts a lot but it will soon pass. Let's see what we can do, my beautiful one, oh dear, it is so painful'. The baby begins to calm down, it would seem that the crisis is over, she lies back on mother's breast, she relaxes, then she moves her little arms near her face and now, with her mouth open, she stays still in that position, maintaining her temperature and feeling containment:

> Mother looks at her watch and says: 'it is nearly feeding time'. And immediately she strikes up a very special attitude with her baby, it is a sort of 'delousing'; it reminds me of the very significant ritual of delousing in monkey mothers. She takes off her baby's bonnet and passes her hand over her head as if combing it, separating her hair strands slightly and scratching the baby's head very softly with her nails, one side, the other side, carefully (what this mother is doing must have a very significant primitive meaning because her concentration and dedication are striking). The baby is fully immersed in this placid loosening up, her whole body stuck to that of her mother like a little frog stuck to a surface that gives it pleasure.

These shared moments between mother and baby express, through sensations, a kind of 'feeding' and a need to see and get to know the interior of the baby. I think that for the mothers of premature babies that daily experience of stroking and rubbing oil on their babies awakens in them the need to investigate them, to get into closer contact with them and to 'put together' a baby which in their fantasy is still a part baby, unborn, incomplete. These actions bring to a mother the capacity to link herself to the 'child in waiting'; as she sees her baby making progress thanks to her attentions and to the feeds she is reassured. The mother in this observation, who is in a difficult personal situation, shows a great deal of interest in her baby, and yet it would seem that the period spent carrying her baby 'inside' has been lived as a time when the baby was not born yet and her willingness to look after the baby that is to be born is great:

> Paty (Andrea's sister) has been looking closely at what mother is doing and she asks her when the baby's hair grew so much; mother says that she was born like that, with lots of hair. She carries on stroking baby's hair for a while, then her shoulders and her arms. She seems to me to be enthralled and to be sending a calling message to her baby, to need to rescue her from her sleep and bring her out of it so as to offer her the feed.

> Then there is a kind of change in this communicating movement. When the ritual has been going on for a while the baby starts to move as if waking up or arriving from a place elsewhere. Her features contract and then stretch; she tries to open her eyes, slowly, then she stretches her hands, her fingers, feet, mouth, and eyebrows; every single millimetre of her is taking part in this momentous message.

It looks to me as if a proposal is on offer to bring together all her different, fragmented parts in a special configuration organised around one object, which is now the pulling force. There is a universe being configured, with a centre, meaning, rhythm, harmony and space noises, or are they voices? There are cosmic lights, a song from the stars and confirmation of belonging to this universe. I imagine that this is what she is getting ready for; will those unknown vicissitudes of the object and of the milieu continue to be the same? Will new things be thrown up by the relational development of that universe?

Baby Sara: how to find a secure harbour

The next illustration of 'an observation and intervention' is about baby Sara. The observations come from the general room at a Kangaroo Baby–Mother Day Clinic and they serve as example of the way I do this work in the Kangaroo programmes in this and other hospitals in the locality:

> the inanimate object does not surge in self-generated impulses… this rhythmical vitality of movement is the first identification of live company. (Trevarthen, 1985, quoted in Alvarez, 1992, p. 82)

This is a dramatic illustration of what I was able to understand about the experience of panic and horror at the possibility of ceasing to exist that this baby lived through. We are going to see, in her, states of very primitive terror that are difficult to understand. They can only be felt and roughly decoded. I understood, through Sara, the tenacity of these little babies in their search for the closest thing to a link to hold on to in order to feel and to be alive. Two interesting aspects came together in this case. One was an experience of panic in the neonatal ICU (NICU; where the baby had been for survival just after her birth) and her response to it. The other was the skin-to-skin experience of having a container with a sufficiently good response to allow in a catastrophic fear that would lead to change and to the recovery of live connection with her mother, strengthening her feeling of being in the world.

Sara was an oxygen-dependent kangaroo baby. I started observing her in the general room of the Day Clinic Kangaroo programme three weeks after she was born.[3] There were interventions on my part in my first visit to mother and baby and at each subsequent visit. Observations and work with this baby–mother dyad went on for more than two months. Here I shall only include what is relevant as an illustration of the mental state of this premature baby and her contact with the world. We shall see in Sara how a strong link with a live object and the actual

breast can lead more adequately to separation than a pseudo link with an inanimate object. To attach oneself to life and recognise its existence is to recognise an object that joins together the baby's senses and sensations and produces live, containing communion that replaces anxious clinging to an inanimate object.

Rita, Sara's mother, is an 18-year-old adolescent; Sara is her first baby and throughout the pregnancy she was in fear of not being up to being a mother. A state of permanent anxiety invaded the experience of pregnancy and stopped the link that joined up the mother–baby couple who were, after birth, in a state of panic. Mother was seriously ill and admitted to hospital with preeclampsia. It was a Caesarean delivery; Rita was semi-conscious throughout, but not able to see her baby. Mother and baby were separated immediately; Sara was taken to the NICU and mother to the ICU. Rita was able to see Sara in the incubator only two days later and then regularly while the baby was in hospital. Her visits were long and she talked about how she felt sad and anxious that her baby might not recognise her or forgive her for, in her own words, having failed, 'This was not what I had expected, I had a different baby in mind', she would say in a tone of fear as if she were making a confession. Rita had a partner, Sara's father, who was close and caring. This helped her to prepare herself as Container for the baby she had not expected but who was now her real baby:

> I am in the Community Care Ward of one of the clinics running the Day Clinic Kangaroo programme. A mother and baby come in; the baby had spent three weeks in the NIC and is now in the Kangaroo programme. Mother is carrying it skin-to-skin in the kangaroo position; the baby is still oxygen-dependent. It is Monday. Mother had taken her baby home on Saturday and has come in for the daily check-up. We are immediately struck by the expression on her face and her untidy look. She seems agitated and is looking for somebody to deal with her. Unlike the other mothers in the programme, who wait their turn sitting in the room, she is crying, distressed. She is asking for help but quietly. There are just tears, helplessness and anxiety. I notice that she is immediately seen to by the psychologist. They talk for about twenty minutes during which the mother seems frightened, inconsolable. The psychologist calls me, rather worried, and asks me to see this mum.
>
> We move to a more private place and sit down. Mother tells me, crying, that she does not know what is wrong with her baby: 'She cries and cries, nothing calms her down; she doesn't want to eat, she doesn't want anything; only when she is tired of crying does she go to sleep'. While listening to her complaints I observe the scene closely, concentrating more on the baby, who is very small then and still at mother's breast. Mother is trying to calm her by rocking her and kissing her. The baby is twisting herself about, her head does not stay still, she stretches it up, throws it backwards and then falls back again against her mother's breast creating an impression of fatigue and protest. She is holding so tightly onto a bit of mother's bra that she seems to be hanging from it. Rita takes Sara's hand in hers but then carelessly lets go of it. She then starts to take her out of the kangaroo position so that I can observe how she puts her

> back in for feeding and how they interact. As soon as she is out of the tight position Sara bursts out in a cry of 'panic'. Mother talks to her, asks her: 'What happened, my love? Why are you crying, what is the matter, what do you want?' The baby yells and the mother cries. After observing that crying, that complaining, that feeling of desperation, of helplessness and a kind of falling into empty space that mother conveys to me, I moved closer. I take the baby in my arms; nothing calms her, nothing soothes her. I begin to see, after trying different solutions for a little while, that the baby is desperately looking for the edge of my buttoned up blouse with her little right hand. Taking this search of the baby as my guide I concentrate on it, paying attention to what she was intending, instructing (?) with that little hand that is trying to take hold of the edge of my blouse. She immediately, desperately and tightly, takes hold of the edge of my blouse and whatever buttons she can as well. She starts to suck in air and space, and her fist closes tightly and dramatically onto the button. Her forehead is in a knot, her mouth is tense and sucking in deeply. Her crying stops, her eyes remain closed and her body tenses up.

Observation 1: 35 weeks gestation

An association of facts slowly takes shape in my mind and I start to understand the mental state of this baby. I can feel what is going on in her psychic reality: she has found a meaningful connexion for her precarious self; she has stopped feeling as if she is falling in space. This is just my own conjecture because I shall never forget that 'coming to rest in a secure haven' that I perceive in the baby as soon as I adjust the bit of my blouse and button inside her fist. She is holding fast onto what seems to be her feeling of being alive. Outside that there is death … psychic death?

> Urgency, horror and desperation may therefore be appropriate responses to some stages of mental illness, mental dissolution and psychic near-death. (Alvarez, 1992, p. 56)

Were my observation and intuition based on reality? Was I taking in the information correctly? Did this baby depend for her life on holding onto something? Was the feeling of existing what was putting her in contact with life? With her life?

In a spirit of research and staying very close to her I very carefully swap the bit of my blouse for my finger and I start to move it, gently, in her hand. She opens her eyes immediately, not looking anywhere in particular, just looking for 'something' out there. She begins to wake up, tightening her hold on my finger and letting go of it and then bursts out crying again. She is tired, weak from crying. Mother is also still crying, and not understanding what is going on she is saying to me that she is tired of the baby's cry and does not know what to do, 'She just cries, she does not look at me; she has not given me her first smile yet. Since I took her home on Saturday she has just been crying; she does not want to be at home with me; she rejects me; she was happy in the Clinic'. I return the baby to mother's arms and we go together for an oximetry test which is essential

because Rita is truly weak and exhausted even though she is still connected to her oxygen cylinder.

I continue observing everything and I feel frustrated by the lack of understanding of the baby's mental state, by not knowing what was causing it. I sit near mother and baby who are both crying. When the head nurse places the oximeter in the baby's hand her fist closes and she clings on to it tightly and stops crying that very instant. She gives a deep sigh and the visible relaxation in her body strikes me quite forcibly as I observe. What is happening? I wonder. What has she found? What is it? I still do not understand. Breathing calmly and slowly with the oximeter in her hand baby Sara becomes quiet and falls asleep. There is a sketch of a smile on mother's face as she looks at her and says: 'Asleep at long last, now we both are going to rest for a bit. We can only rest when she is asleep'. I observe her all the time as she sleeps. Her oxygenation reaches the peak and I look at her as she sleeps peacefully inside her girdle, skin-to-skin, still and stuck to mother's body. Dreaming perhaps of a link to life that makes her feel that she exists:

> Then the nurse takes the oximeter away. Baby, who was asleep, begins to make faltering noises, sobbing and beginning to wake up. Mother starts to get anxious and the baby is now openly crying. I want to repeat the previous scene to check whether my feeling, of having understood it correctly is right. We put the oximeter back in her hand, the crying stops; she opens her eyes and begins to make sucking movements, quietly. Mother gives Sara the nipple, she takes it in with force, like the oximeter; she is half-closing and opening her eyes and her sucking is strong and calm. Mother also calms down. Sara keeps the oximeter in her hand and I understand from the way she is holding it that it is her link to the feeling of being alive. In these observations it seems to me that she is taking the nipple in her mouth in order to close the hole that told of the separation or something worse. That little device, the oximeter, keeps her reassured that she exists. She makes occasional movements as if rearranging it and securing it in her hand. My thought is that it is like a part of her, it is a discovery, a feeling of 'I've got it': that little hard object that can barely fit into her hand seems to be the accompaniment of sucking, breathing, and of her existence. Baby and oximeter are one at that moment. I understand this baby's attempt to link, to relate; I see that the link is with that object that could fit in her hand, a hard object that was always within reach. This baby appears immediately in my mind in the incubator, almost hanging from whatever she could find near, I think of the cable of her oxygen cylinder or the oximeter itself. Baby and mother were not two; she had not lost one piece, she was not getting lost in that black hole through which mum disappeared if she did not grasp her inanimate object-mother in her little hand. Only then could she breathe properly, suck proper; be alive.
>
> I move closer and I start a conversation with Sara and her mum. I tell them very slowly what I have understood, what I believe Sara has communicated to me. From her position of being stuck to her mother's breast she pauses, opens her eyes and is quite alert, she looks out but makes no movement with her mouth; I go on talking and in

> the short pauses she makes I go closer and start to touch her hand which is holding the oximeter tightly; I am touching her object-hand. Mother looks at me quite perplexed. I explain to her baby that when Sara has the little device in her hand, like a cable in the incubator, she feels she is holding on to life; that for her it is salvation, something that seems to fill the space left by someone, perhaps mum? I begin to place my finger on the device and she lets go of the nipple and seems to be frightened. The crying starts. I try to show her through feel that the oximeter is still in her hand, readjusting it so she can feel it is still there. But I also kept my finger there, a live, animate object. My intention now is to continue moving my finger inside her hand while looking at and speaking to her. We stay like this for some hours. Sara and her mother calm down. Sara is accepting my live object-finger and I say to mother that her baby seems to imagine that the little device was her, mum, and that she cannot let her go because it gives her reassurance and life.

I give mother some suggestions about how, little by little, she herself could be company for the oximeter or that she could 'replace' the cable that Sara had in the incubator, these hard objects with which the baby has made a life pact through which she exists and feels alive so long as she holds on tight. But from now on this permanent experience should always include mother's finger, her hand and her skin: live, moving objects, and to this she should add her voice, the sound of her breathing, her gaze … always trying to integrate her senses in her communication with Sara. Thus, the object-nipple in the mouth-hand could become the object-nipple in the mind, which is the 'focus for the development of the psyche' (Tustin, 1987, p. 29).

> Without hurry, without tension, mother would substitute the hard object by her fingers, her hands, her body, while she talked to the baby and told her what was happening. She would be reaffirming herself as the linking figure with her baby. Perhaps because she wants to check this out, after a while, mother puts her finger next to mine, together with the oximeter held tight by Sara. She cries again looking at Sara, and seems to have understood; she is calm. Her crying is different; she seems to be crying in a different way because she can understand her baby, really knowing her again.

Now mother felt closer to her tiny baby. She could see that she was doing something about the situation that was making her desperate; she understood better. I thought that a way to maintain this kind of observational and containing relationship with her baby would be to help her practice, using me as a container, by communicating her observations, feelings, thoughts that came up during the period when she was involved in the transformation of the link with her baby. That is to say the move from an inanimate to the animate, live object, to mother herself. So in each daily visit to the programme, we had an analytic conversation about what she had discovered, understood and secured in her relationship with Sara. I began to see a calmer mother, who had a growing capacity to talk about her baby and especially *with* her baby. Mother's and Sara's world became more and more complex, rich and alive.

Verbalising her observations and experiences with Sara, and thinking about them with me, made them more digestible and put them in a different context. Thanks to my capacity to think about what was projected into me, my alpha function, this mother could transform the experience into something thinkable; she was placing it at a different level of symbolisation; she remembered what she had told me and she thought about it again and again. Everything was becoming what I would call alpha action (Bion, 1962–1988); the alpha function in her mind was taking charge of her relationship with her baby, little by little and more and more frequently; this was becoming a relationship of mental growth or of growing 'container-contained'(♀♂)^n. Sara could now feel that her mother was real and effective company for her, less depressed, less desperate. She was a mother who was giving names to things, looking, talking and calling Sara to life. Little by little this would make this baby feel strongly that she was alive in herself as well as in her mother's mind. If the mother herself does not have the emotional experience of containment, carried out by the immediate external world, it is extremely difficult for her to provide it for her baby.

Discussion

Through Sara I saw the subtlety of mental states that are hard for us to imagine: states that have a special quality of relationship with life and with death. Her story was a very delicate narrative of rupture in the combined mother–baby unit. For some years now, since I have been an 'emotional kangaroo' for these dyads, I have noticed the unequivocal impact on myself of the mental states of these babies. It is really as if they were still in the womb, when they are, in fact, outside and separated before their time. Tustin (1987) stresses that this fact is of vital significance when autism is suspected in babies some of whom were full term, but who experienced bodily separateness from mother as a trauma:

> Clinical work with psychogenic autistic children in whom no brain damage can be detected by the investigative methods at present available indicates that they developed as infants a massive formation of avoidance reactions in order to deal with a traumatic awareness of bodily separateness from the mother. This impinged upon their awareness before their psychic apparatus was ready to take the strain. (Tustin, 1987, pp. 22–23)

And it is not just a question of the physical separation. Observations suggest that it is the mental union between baby and mother that suffers the most in situations of extremely premature birth. This lack of connexion is dramatic. It is as if the premature rupture in the mother–baby union causes terrible disruption to the 'reading' of the communications from the baby. Where will the signals he sends go to now? To what mother-mind? The mother feels lost and does not know how to re-establish them.

There is more and more research being done on the effects of mother's absence on the baby. Maternal depression has palpable consequences on the emotional and cognitive development of the baby. Anne Alvarez (1992) in her

book *Live Company* referring to this, quotes Trevarthen (Murray & Trevarthen, 1985) countless times. My own experience is one of surprise at seeing how relevant is that tuning-in between observations and understanding. Trevarthen, Alvarez writes, states that:

> the inanimate object does not surge in self-generated impulses … this rhythmical vitality of movement is the first identification of live company. (p. 82)

It is well known that autistic children establish relationships with inanimate objects, whether they are hard or soft. It is my opinion that Sara's abrupt separation from mother at 32-week gestation was a rupture more than a separation because it ripped the container-contained function. A three-week-old baby in the silence of a night that is dark because of the absence of emotion and of the intimacy of touch, besieged instead by the predators of pain, discomfort and absence, adapts her sensations to the objects connected with her existence, cables, inanimate objects, inhuman sounds and cold and intrusive contact. Perhaps she experiences crying that finds no echo … a hard landing in the world.

That little device, that cable in Sara's hand, made her feel that she existed. My finger was intruding into her certainty. She would have to tolerate something live in her hand, take it all the way to her mind and wait for it to expand throughout her whole being: a hard task for this very small baby. Once she came out of the NICU she was lost, she could not find her linking object, her vital oximeter, the cable that saved her by staying in her hand, always present, faithful and permanent, for three weeks. Now it was not there and life seemed to be absent too. What could she hold on to when her experience was not of a psychic centre that held her together? She was only able to plug that hole with inanimate objects. I see it as imperative to help mothers to help their babies into a live, cooperative activity. This becomes urgently necessary in order to free up innate movements that were blocked by the traumatic experience. Sara needed to transform the experience she could not process in her premature mind, her beta elements; she needed a living figure to provide the maternal rêverie required so as to be able to discover the live object that would accompany her new experience. My function was to facilitate linking this dyad.

The mother, who was also very young and unsteady as she applied herself to maternity, was in need of a strong containing presence who could understand how frightened she was about not being able to bond with her daughter. She thought she was failing; she thought that she did not deserve her baby's love; she did not know how to understand her. There was a challenge for me here seeking desperately to help the baby to find 'live company' (Alvarez, 1992)

Our work together took us longer than the time that passed reaching the point when Sara would have been born had she been a full term baby. The transformation was slow but steady. By the time I stopped helping mother through my participant observations Sara was a baby who made eye contact easily, called to her mother, gurgled, smiled and fed placidly from the breast.

While she sucked at a calm pace she touched her mother's breast gently, without any anxious clinging; caressing a breast that was a safe 'harbour' for her linked to a mother who was there and could hold her in mind. I was present, I think, at those 'moments which hold in suspense the possibilities of both "break-down and break-through"' (Bion, 1966, quoted in Meltzer, 1994, p. 53). Performing urgent alpha function for this baby–mother dyad was enough of a container for the mother herself to do the observing and to connect with her baby's mental state. In this way she could begin to build a container mind for both of them. My last thoughts about Sara are of admiration. This little baby protested, fought, got cross and made her object respond. She held on to life with tenacity, she went beyond mum, actually calling and calming her. She succeeded in playing her part in creating the container that was to connect her with life.

Notes

1. I have added an exclamation mark after the two first parts used by Bion (1963–1980, p. 122), ♀♂ who used them to indicate 'container-contained'. The exclamation mark indicates danger to the baby in relation to the capacity of mother-'container' to contain her baby-'contained' (♀♂)!
2. Some, of course may be born premature because they are ill, but there are any reasons why babies are born prematurely.
3. Due to its height, 2600 m above sea level, it is common in Bogotá for newborns to need oxygen for some time. In the Kangaroo programme quite a few of the babies go home with oxygen without any problem. I was not able to observe this baby in the NICU because she had come from a different hospital from the one to which the Kangaroo programme takes place.

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