Infant Observation: International Journal of Infant Observation and Its Applications
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/riob20

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Version of record first published: 19 Aug 2006.

To cite this article: Nicky Hardy (2005): A premature view: Observations in a SCBU, Infant Observation: International Journal of Infant Observation and Its Applications, 8:2, 169-176

To link to this article: http://dx.doi.org/10.1080/13698030500171597

Infant Observation, August 2005; 8(2): 169–176

Routledge
Taylor & Francis Group

A premature view: Observations in a SCBU

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Abstract
I was aware in my current work, particularly the Under 5's clinic, how many of the children referred had spent some time in the transitional environment of the special care baby unit (SCBU). I wondered whether this early trauma influenced the neonate's neuropsychological development, or whether changes in relationships became more permanent with states becoming traits. I was interested in what the experience might have been like, for both mother and baby, and how this might have emotionally impacted on their developing relationship. Whilst considering the effects of SCBU, it must be acknowledged that all babies are admitted because something has already gone wrong, perhaps indicative of innate vulnerabilities, and that without this intervention many would not survive. During the course of the observation, I also found myself considering the impact of the experience on staff and myself.

Keywords: *SCBU, observation, premature infants, nurses*

The observation setting

The special care baby unit is a relatively new development on the top floor of the maternity suite. It has two bays, the 'hot' bay for more dependent babies, and the 'cool' bay, which is still unbearably warm, for those who tend to be 'growing' towards discharge. Each room can physically manage a maximum of six babies, with a small room offering an 'over-spill' facility for two further cots, or isolation nursing, if this is required. Due to the lack of high dependency equipment, any babies weighing below 1000g at birth, or born prior to 30 weeks gestation, are transferred to the regional centres, both approximately an hour's travel time away. The babies are readmitted to this local facility when, and potentially if, they grow a little and stabilize.

I was initially given a tour of the unit and introduced to the Sisters in charge by the Paediatrician. Whilst she was clear about my being a student, wishing to attend just to observe, I feel that this personal approach did confer a sense of her approval. I was aware from previous experience of hospital settings, and the literature, that staff can be defensive, to the extent of seeming hostile and unwelcoming. This may be an understandable reaction to the anxiety aroused by having someone watching their work, with all of the implications that this may involve. My expectations and fears seemed unfounded. They appeared very open, stating that I could come 'anytime'. They didn't ask about how I might approach the parents, or whether I would seek permission from them about observing their babies. I was left with a sense that presences and absences weren't clearly delineated, as if I could visit,

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ISSN 1369-8036 print/ISSN 1745-8943 online
DOI: 10.1080/13698030500171597

but no one would notice or think about it. I wondered about the permeability of boundaries and containment within this environment, and the ownership of the babies, between the institution and the parents and how these delicate issues were negotiated, or not. The sisters did suggest that I brought a photograph for the 'staff' board, again to validate my presence and reduce people's anxiety – but in an unacknowledged unspoken way.

The observer role

Whilst I had originally intended to focus my observations on the mothers and babies, I frequently found myself observing the wider context of the ward staff. There are several references in the literature to the painfulness of observing the vulnerable babies within SCBU, identifying with their experience of persecutory anxiety and holding their very real sense of overwhelming struggle for life in mind (Negri 1994, Cohn 1994). I felt that I naively underestimated the emotional impact of the observation experience, despite the more knowledgeable grimaces of my nurse-trained colleagues within the seminar group. The intolerable anxiety of observing, and thinking, may explain why, in the absence of any organisational structures or mechanisms for discussions, or time to think, many of the staff busy themselves with the very real tasks of procedures and routine care, rather than being able to offer containment to the families. The unbearable emotions seem to remain projected and split off, played out in the relationships on the ward, rather than being identified and acknowledged.

An early observation conveys the rawness of observing babies who are alone.

> The baby was lying in only her nappy, in what looked like a wonderfully relaxed "open" position over the edge of her nest. She was sound asleep, undisturbed by the constant beeping and alarms on the monitors, which seemed so intrusive. She seemed to be breathing steadily and easily, and had comforting baby plumpness about her, which was obviously enough to prevent the constant concern over body temperature. The doctor had taped some strips of plaster to the inside of the incubator lid in preparation, and had lined up a variety of other bits and pieces on the top of the lid. He looked over the baby, checking her feet and hands, making a comment to the nurse helping him on the other side of the incubator, that he was going to try to find a vein in her foot. One foot was covered with the standard "red light" monitor, and was unavailable. He took the other ankle and tapped it with his hand, trying to encourage the veins to the surface. The baby didn't appreciate the wake up call and complained. He kindly apologised, and talked gently, saying that he wouldn't be long. I could sense that he was reluctant in his task, and I wondered too if the baby sensed his hesitancy and anxiety. The doctor inserted the needle into the tiny foot, holding it tightly so that it resembled the same purple colouring as the "lit" one. He shook his head and removed it, covering the puncture wound with some cotton wool. The nurse had her hand on the baby's tummy, partly to stop her from wriggling, but also to give the baby some human connection I think, as she talked to her quietly. The doctor picked up her hand and looked at it closely. There was already a purple line over the back of it. He bent the fingers over and tapped the back of her hand. I was aware of myself fidgeting uncomfortably, crossing and uncrossing my legs, flushed. I tried to bend my hand like the baby's and couldn't do it, just the positioning looked painful. The doctor then asked if I was the mother. He looked relieved at my response, and I too was glad that she wasn't present to witness the struggles of her newborn. He tapped again, shaking his head. He seemed in two minds as to whether to try to get a line in, and then had a go, inserting the tiny needle. I'm not really sure what the baby was

> doing. I was almost mesmerised and aware of keeping myself together. He then withdrew the needle and shook his head again, commenting that all of her veins were collapsed; he wasn't sure what to do. I felt relieved that he had stopped, and at the same time horrified at his comments, which in my mind are associated with long-term intravenous drug users.

Whilst this is a lengthy quote, it perhaps demonstrates the emotional impact of observing babies alone. The baby was originally in a physiologically stable state of deep sleep, highlighting the lack of thought about the timing of interventions from the baby's point of view. It illustrates the staff struggles, knowing that their necessary procedures distress the babies. And I hope it demonstrates the difficulty of remaining focussed on the baby's unmediated emotional experience, potentially stretching the observer role to the limit.

I tended, therefore, to gravitate towards babies being held, whether physically or by the presence of (usually) the mother. I wasn't aware of this as a conscious decision at the time, but on reflecting on my own ways of managing the pain and sadness ever present in the unit over the course of the observations, this was clearly apparent. I felt somewhat vindicated by Cohen's (1995) comments, that when observing infants alone she would take notes, unlike her usual practice, as if by doing something she could distance herself a little from their very real struggle for survival.

When mothers are available to offer some physical and/or psychological holding, watching the babies was not so painful.

> I looked down into the incubator and saw a tiny baby on its "nest", being incredibly active. Both arms shooting up to the ceiling of the incubator, hands and fingers outstretched, and both legs, stiff and straight, being drawn upwards as well. She seemed to be rolling her head from side to side, her pupils shaking periodically in their sockets, as if not clearly able to focus or hold on visually to much in the outside world. I was aware of her scrawny appearance, again the "ET" fingers, accompanied by rather prominent bags under her eyes, and the feeding tube extending from her nose and tapped to her yellow jaundiced cheek. She seemed to be flicking her tongue in and out of her mouth, as if hungry, and I thought that her rolling head movements might well represent her attempts to root out a breast. Mother took hold of her tiny hand, gently allowing Bethany's fingers to curl around just one of her fingernails, and thereby enable her arm to steady, whilst mother soothed her, stroking her fingers and talking calmly to her, reassuring her with her presence and connection.

In contrast to observing newborns alone, this quote illustrates that when mothers are present to mediate some of their infant's emotional experience, observing becomes more bearable. The babies developing relationships can also be viewed.

My presence as an observer in SCBU certainly seemed to make it more possible for others to start to think too. For example, on one occasion, I had just walked over to observe the only singleton baby in the ward, housed in her incubator, screaming loudly, when one of the sisters, a kind but somewhat efficient and brusque nurse approached:

> She announced that this little girl had been playing up all morning, had just been fed, but still wasn't settling. She wondered whether she needed changing again. She carried this out efficiently, talking to the baby throughout, but in a fairly authoritative way. I commented out loud that her heels looked sore, and the nurse 'reassured me' that it was only scabs from repeated heel pricks from blood sugar tests and that these would heal quickly. She added, I think for my education, that often babies of diabetic mothers, where

> these tests were done more frequently, were 'toe walkers' when they reached this stage in their development. This seemed to indicate to me some memory of pain in the heel region, and also the potential long-term effects of some of the medical interventions undertaken within SCBU. She made no reference to this. . .She turned the baby back over onto her stomach. She was instantly still and quietened. The nurse then commented again about how amazing it was that she could communicate her distress, and that simply by changing her nappy, this could be overcome. That she could effectively make her needs known at only 6 days old.

I wondered whether my presence was unconsciously making the nurse think a little more about the babies in her care.

On another occasion, one of the mothers who had been on the unit for several weeks, asked me whether babies as small as this felt jealous. I was interested in her question and the underlying thoughtfulness about the babies' experience. I enquired as to what had made her ask. She nodded towards the far cot, to a little baby who was frequently irritable. His cot was adorned with all manner of activity arcs, music boxes, mobiles and even a mirror, all of which I felt were to compensate for the lack of a maternal presence, even accentuated by the mirror reflecting the fact that he really had to hold himself together. The nurses spent a lot of time with him, carrying him around as this helped him to settle. He was full term, and appeared bonnie in comparison to the other occupants, especially the baby of the mother who had asked. Her baby had been the most premature of all. The mother explained that all of the other babies bar this one had a visitor and perhaps he was envious. This mother had sat by her baby's cot every day for eight weeks, putting her life on hold whilst she willed him to keep hold of his. I think she was sensing this child's loneliness and pain. I commented that he may be more aware of the absence around his cot rather than the presence of mothers elsewhere. I'm not sure if the other mothers were aware that he was a heroin baby, getting used to managing without a physical dependency too.

Containment

The mothers play a vital role in containing their babies. Bion (1962) talked of the infant's need for a mother who could receive his distress and negative projections, consider them and respond appropriately. The infant reintrojects these fears and anxieties in a manageable form, as well as the experience of an object who has been able to tolerate and think about them. Introjecting this maternal 'reverie', the infant becomes more tolerant and able to make sense of the world in terms of meanings. From another point of view, this containing function of the mother may be seen as holding the parts of the infant's personality together in his primary unintegrated state. This would be optimally by the nipple in the mouth, and the familiar holding, smelling, talking mother, who meets his various sensual needs. Thus the mother functions as a sort of primal containing "skin" (Bick 1968).

However, in this transitional space of incubation and prematurity, for them as parents too, I felt that their needs were often overlooked. It seemed so hard for them to be "good enough". To spend as much time as possible with their babies, whilst still managing other family commitments, travelling, sometimes long distances from home to the hospital, as well as looking after themselves, so that they could provide adequate breast milk and also recover physically and psychologically from the trauma of the birth. Anxiety was often apparent from the demands of these competing needs, but this was not acknowledged by the staff, nor were reassurances offered. Staff were generally jolly, not seeming aware of the huge loss of intimacy for the mother-infant couple as a result of their enforced separation. I

overheard a conversation between parents about whether they thought that their babies would be adversely affected by this experience. It rapidly moved on to thinking of the amazing ability of plastic surgery to hide hideous scars and disfigurements. Whilst this seemed to portray their sense of the potential damage inflicted, the mothers were unable to think about or tolerate those aspects that are 'under the skin', and may not be healed by adding superficial layers.

On one occasion, a young couple gave permission for me to observe and left to return to the maternity ward after about 10 minutes, commenting that they were happy for me to continue. I actually felt that my presence watching over the baby helped them to leave her.

> She was newborn, one of only two occupants in the unit that week. Neither was attached to monitors, so the place seemed eerily quiet. Shortly after her parents' departure, she started rooting and smacking her lips together, looking hungry and agitated. As her screams increased, the children visiting the other baby became louder in their play, as if trying to drown out her distress. I wondered if the sound was echoing within the incubator, amplifying her cries, but still not receiving any response. Just watching, I felt desperate. Her tongue was vibrating in the middle of her open mouth, her eyes screwed tightly shut and her arms straight by her sides with her little fists clenched. I wondered whether to alert the staff. In the absence of monitors, no one seems to see how the babies are... Eventually, after 25 minutes, one of the nurses came to check her, commenting that she had telephoned down to the maternity ward, and mother was on her way. She picked her up and cuddled her, announcing that she thought she was probably hungry as mother's milk wasn't down yet. Mother waddled in, looking terribly anxious and apologising for the delay, but she'd been attempting to have a bath, hastily abandoned on receipt of the phone call. The nurse handed the baby, and the responsibility, to mother. At the sound of her mother's voice the baby instantly quietened. She turned to me with a sense of desperation and asked if she'd been crying for long? "She stopped when she heard your voice," I replied honestly, trying to reduce her pain. She looked relieved, fed her and decided to stay a while, just to hold her.

I wonder if, by experiencing some sense of containment, this mother was helped to feel able to manage her baby, rather than guilty for leaving her. This observation also demonstrates the limitations of relying on monitors and technology to look after the babies, as in the absence of such machinery, there is a temptation to no longer 'see' the baby, or think about his needs. However, the emotional strain of observing such fragile beings, with their raw unprocessed emotion, cannot be underestimated. Offering this container function requires the provision of supervision, that is, a reflective place for staff, in order to help process the unmediated emotional material and reduce the likelihood of this becoming split off and projected, denied or remaining unacknowledged. Thus for the infant to feel contained by workers in the institution mentally holding him, the institution in turn must offer some containment to its staff.

Ownership of the babies

Through my observations, I became very aware of how inadequate many of the parents felt, as if by giving birth prematurely, they had already failed to some extent. The compromised baby, for whatever reason, cannot manage to sustain himself without assistance, and yet his reliance on this artificial environment necessitates a separation from the mother. For the mother, the handing over of her baby to 'special' skilled professionals and surrogate

incubation diminishes her parenting role psychologically and practically. This sense of impotence may well mirror that of the infant, and opportunities to work through some of these issues may have helped the parents to offer a similar integrative function for their premature infant (Bender 1991). It seemed that many of the mothers were undermined further by the lack of opportunities to think with the staff about their babies and their very real worries now and for the future.

Even when mothers seemed to be managing to establish a relationship with their infants, in conditions of limited privacy and space, there sometimes seemed to be a lack of sensitivity in the nurses' communication. I observed a mother feeding her twins:

> She was talking quietly to Aoiffe as she fed her, "What a good little girl she was", and noting her features. The baby looked asleep to me, a tube taped against her face, and a shock of dark hair visible peeping out from the swaddling blankets. The nurse approached and said that she thought she should have the rest of the feed via her tube as she seemed tired, and it was time for Patrick to have his feed. Mother said nothing, but I got the impression that she didn't welcome the intrusion into the interaction with her daughter. Her eyes flitted around the ward, hyper-aware of the other babies' cries, but also frequently towards the door, as people entered. . .Mother didn't actually agree to the tube feeding, but this was swiftly and efficiently managed by the nurse, who handed mother back the syringe, encouraging her to hold it higher so that gravity would work. Mother obliged.

On reflection there seemed to be an unspoken struggle about control and ownership in this interaction, with mother not verbally responding to anything the nurse said, almost gaze avoiding, but with a sense of dependence and having to relinquish to her expertise and therefore helplessness. The interaction seemed to emphasize the natural quandary with twins, of never being able to satisfy both simultaneously. Always feeling guilty that one is missing out, and having to manage the difficult balance of giving each individually enough. After changing her other baby, mother started to bottle-feed him too:

> She was trying to encourage him to suck, and struggled to get him to open his mouth again having winded him. By the time she had massaged him into opening his mouth and then picked the bottle back up, he had closed his mouth again. The nurse called over to enquire about his progress, at which mother replied fine. The nurse commented that being the smaller twin, he would be slower, and that the twins would develop at different rates throughout life. She reassured the mother that there was no hurry, but then, what seemed like a few brief moments later, said that she thought he should be tube fed too as he had attempted bottle feeding over the last few feeds and maybe was too tired.

I wondered about this premature baby's capacity developmentally to be able to sustain a sucking response, but also felt that the nurse had been insensitive to the mother's needs and feelings, and possible resentful projections, leaving her perhaps interpreting this as wearing him out, or her not managing the feeding "right", and that the skilled staff would know better. It seemed painful, and I sensed that mother was "biting her tongue".

Another mother, who had been with her baby in SCBU for some weeks, announced to me on my arrival one day, that all of the mums in the bay had made a pact to take their babies home on Mother's Day, if they hadn't been discharged by then. This simple statement, made in a mischievous manner, had the undertones of frustration, of a sense of the babies not legitimately being theirs yet, and their motherhood not being truly

recognised. It was as if the birth, and their status, would only feel real when they left the hospital.

Hope and despair

I felt very privileged to observe the intimate moments between the mothers and their babies. Some had struggled through the dark early days of uncertainty, with the mothers willing their babies to stay alive, "claiming" them back almost, when containment seemed too passive a role. And slowly, the small movements of vitality blossomed into the communication of reciprocity.

> Mother was seated, cradling one of the girls in her arms, gazing down at her with her head tilted sideways, aligned with that of the infant's. The baby looked perfectly content. Gone was the gaunt, scrawny look of the premature 2lb 4oz baby. She had grown into a perfect miniature girl, still only 4lb 7oz, but with rosy cheeks, her lips touching closed, and her eyelids too softly together. Her arms were outstretched, but there were no jerky shaking movements, even evident last week as she'd struggled to manage her mother's breast. Her tongue had been strong, flicking in and out, seeming unable to co-ordinate latching on and sucking with her oxygen intake. Mother looked up at me, and said with a sense of deep (I struggle to find an appropriate word) perhaps satisfaction, relief, achievement, or love, that this was the first day that Kylie had been without any of her tubes. She had that sense of maternal preoccupation, and wonderment of a new mother seeing her baby for the first time, and being enraptured by her beauty, allowing herself this privilege after her trauma and weeks of hopes and fears for her babies.

In stark contrast, on the same day, I was also aware of a baby who had been crying incredibly loudly. I wandered over to stand closer and hence a better position from which to observe.

> I watched in fascination as the nurse seemed to be feeding him by pushing the bottle into his mouth, holding his head firmly in her other hand, almost willing him to suck, squeezing a straight portion of the bottle below the teat. He looked a little ungainly, spread-eagled and uncomfortable on her lap. I sensed that she too seemed to be struggling.
>
> She put the bottle down and winded him, but he kept his mouth open, his eyes staring straight ahead, unseeing. The baby looked quite grotesque in a way, although I felt somewhat guilty even thinking that. His eyes seemed to bulge as if he had an over-active thyroid, although his pupils were a little rolled back into his head. His eyes didn't glance around the room with interest, focussing. He was large, with big puffed out cheeks, and his redness emphasized by the white towelling of the baby-grow, which was buttoned up to his neck. Something about him wasn't right. I wondered about hydrocephalus, or foetal alcohol syndrome, but his features didn't seem to fit. Something about his inertness, the lack of gross motor movements, nothing about him exploring his surroundings or reaching out, that was disturbing. He didn't fidget, or suck, his mouth hanging open, but with no hint of a protruding, potentially stimulating tongue or a turning towards the bottle and rooting. Indeed, this baby wasn't looking for anything or anybody. Unlike the other balloons at the cots, instead of "Congratulations", his read "Get well soon". I wondered whose hope that was, and instantly felt saddened by it.

The contrast in these observations seems to emphasize the richness of communication of most babies, even those who are very premature. It also raises the very real possibility of disability and death that all mothers fear.

The observing experience is perhaps reflected in the structure of this paper, showing fleeting glimpses of different babies, the emotional bombardment mirroring the transient but emotionally enduring impact of the babies' stay in SCBU. The experience of separation and loss was continually repeated for the staff, with little knowledge of what has preceded the baby's stays, or what will happen when they leave.

The observations were made more tolerable by the space to think and reflect provided by the seminar group. Perhaps the provision of such a forum for staff would enable them to start to think about the experience of being in SCBU for the mothers and their newborns without being overwhelmed. Through such an increase in thoughtfulness, the staff may be able, in their turn, to 'promote conditions in which she [the mother] has a chance to think about, to notice and to respect what he [the baby] is. Respecting the baby, the small child from the earliest weeks of life, means giving him a little time to express what he feels, to reach out a little to explore the world as far as he is able, and a chance to discover his own feelings as they arise.' (Harris 1978) Holding onto the belief that my observations and interest in the mothers and their babies might have helped in some small way, helped me to be less overwhelmed by the experience of SCBU.

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