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Peek-a-boo: Play and communication with a critically ill baby

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Abstract

Informed by psychoanalytic and child development theories, this paper explores the therapeutic value of play with a severely ill one-year-old in a neonatal intensive care unit (NICU). It focuses particularly on the game of peek-a-boo and how it enabled this baby to communicate.

Keywords: *NICU, play, peek-a-boo, containment*

I begin this paper by exploring some psychoanalytic views on play, particularly the meaning and relevance of the game of peek-a-boo. I go on to examine the therapeutic and developmental aspects of play and their link to the relationship experiences that enable children to play symbolically. Finally, I present material from my work with an infant with whom I played games, which developed into peek-a-boo, on a neonatal intensive care unit (NICU). I aim to show some of the ways in which the therapeutic relationship can be seen as a major promoter of the capacity to communicate through play.

Child development and psychoanalytic theories consider play as very important. It is both a significant promoter of a child's imagination and a reflection of his world view and his developing relationships within it. It indicates the ways in which the child perceives and understands himself, others and his environment. Changes in play can reflect progress in general development or areas of emotional difficulty. In psychoanalytic writing it is considered to be an expression of the child's unconscious wishes and anxieties. The child's ability to play symbolically has been valued highly by many clinicians and is considered of the utmost importance for the child's emotional development (Freud 1920, Klein 1921–1945, Winnicott 1971).

Peek-a-boo is one of the most universal of children's games. It is played by babies as young as 24 weeks (Kleeman 1967) and is looked on as a landmark in a child's development during the first year of his life. According to Piaget (1962), a pioneer in the theory of cognitive development of children, the very playing of the game depends on the child having some idea of object permanence, in other words the capacity to recognize the continuing existence of an object even when it is out of sight.

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The significance of early play from a psychoanalytic perspective

Freud first observed play in 1920. His 18-month-old grandson was frequently engaged in games, which consisted of throwing a toy away from himself, into corners and under furniture. This gave the child great satisfaction. Freud also noticed how his grandson made a wooden reel appear and disappear by throwing it into his cot, then pulling it back, whilst saying 'there'. Although this is not a peek-a-boo game, Kleeman (1967) points out that the intentional dropping and retrieving of objects require similar skills, express similar motivations and appear during the same developmental period. It is, thus, psychologically similar to peek-a-boo.

Freud, by discovering an unconscious motivation behind this recurring game, considered it an essentially meaningful act. He saw it as the child's attempts to come to terms with the emotional experience of his mother's absence. The repetition helped the child to compensate and develop mastery over the separation from his mother by turning the passive situation of being left into an active one, where he is in control rather than at the mercy of his mother's comings and goings. This role reversal could actually become pleasurable, as it would enable him to pass on the 'disagreeable experience and revenge himself on the substitute' (Freud 1920). Thus, the child was throwing an object away as if to say that he did not need his mother. In a symbolically effective way, the child was now sending his mother away himself, rather than have her leave him of her own accord.

In Freud's understanding, children repeated significant emotional experiences as a means of gaining mastery over them. Play was a way of negotiating between frustration, unmet needs and the reality of absence. The repetition of the game was also a compensation for the cultural restraints placed on acting on an instinctual impulse by turning this unpleasant experience into a 'subject to be recollected and worked over in the mind', as well as 'a revolt against passivity and a preference for the active role' (Freud 1931).

One of the pioneers of child analysis – Melanie Klein – developed a technique for child psychoanalysis focusing on the meaning of play. She was inspired by Freud's discovery of childhood neurosis. She also drew from his understanding of dreams as a mental function providing access to the unconscious mind. Klein (1929) stated 'I discussed the very considerable analogy which exists between the means of representation used in play and in dreams and the importance of wish-fulfilment in both forms of mental activity'.

Klein's discovery of a play technique also provided her with direct access into the child's rich unconscious world of phantasies and object-relations. She used a variety of small toys that she provided for the children as a vocabulary, in the way that words, free association and dreams would do for adults.

Klein's (1952) understanding of repetitive actions in the game peek-a-boo was similar to Freud's. She too considered the cotton reel game as a means of expressing and overcoming the feelings of loss and grief which are experienced by a child when separated from his mother. However, for Klein, instinctual drives shape the inner life of a child only to a certain extent. Taking it further, she proposed that a child's inner world is largely formed by his relationships – especially the initial one between himself and his mother.

She thought that the child communicates his inner world through projective processes present in play and personification and that, with the help of an analyst, this inner world could be understood and modified. The therapeutic value of play was determined by the analyst's interpretation of the transference situation as a way of gradually modifying anxiety and the nature of the objects of the inner world (Klein 1926). Hoxter (1991) suggests: 'play is of a particular value to the child, as it provides possibilities for anxiety situations to be faced in a symbolic way. The anxiety itself is reduced to tolerable and manageable levels.'

Amongst Melanie Klein's young patients, there were children who simply could not play. She described them as too inhibited or too overwhelmed by anxiety to be able to play. Ill-equipped to endow the world around them with any symbolic meaning, they simply took no interest in it. That led Klein to believe that if symbolization does not occur, the whole development of the ego is arrested. However, by interpreting the underlying feelings of hostility, fear or guilt in a child, she noted that her young patients could experience initial relief – and so begin both to face and to express their own feelings in play.

Winnicott (1971) contributed significantly to the further understanding of play as essential to a child's mental health. He remarked that the cotton reel could stand for both the external and the internal mother. The internal mother becomes externalized and represented by the reel. By throwing the reel away, the child, whose aggression has been stirred by being left, symbolically gets rid of both the external and internal representations of his mother. However, by bringing the toy back, the child is reassured about the fate of his internal mother. The retrieved toy indicates to the child that his internal mother has not been lost or killed by his aggression, but is still there, revived, undamaged and 'willing to be played with'. By playing at throwing and retrieving objects, the child feels he has made reparation and revived his mother whose loss he fears. He also revises his relations with things and people both inside and outside himself. As a result of this ability to master loss, the mother's absence becomes more bearable and the child does not fear her return.

Winnicott believed a child's anxiety inhibits his ability to play. He needs the safe space provided by an adult who will be present when the boundary between phantasy and reality becomes obscure. Otherwise the excess of anxiety would make the play cease. Winnicott (1941) notes that the external and internal mothers of a child are very closely bound. An infant cannot clearly distinguish between them. As a result, the child not only fears the loss of his external mother, but of his internal mother as well. The child's internal mother reflects his own loving or terrified feelings, which could switch rapidly. Every time the child's mother goes away the child's relation to his internal mother is tested. For a child who does not build a secure inner object, the disappearance of his mother equates to her loss.

In peek-a-boo, the mother's reactions confirm to the child that the mother experiences the same feelings he does when she is not with him, in other words that she is sad when he is not with her and happy when he returns (First 1994). This process then encourages the child to imagine that the other can feel the same way towards separation and meeting. This is a step towards an understanding of others and the feeling of being understood, on which the social and emotional life of a human being is based. Peek-a-boo helps the child to establish the self–other boundary and so to consolidate a sense of inner representation of the self and the other.

Thus, Winnicott saw play not just as a means of resolving conflict, but also as an exploration of different experiences.

He considered that one of the therapist's most important tasks, with patients who could not play, was to help them to do so. Contemporary therapists, such as Hopkins (2002), Slade (1994) and Alvarez and Phillips (1998) support this view. Slade (1994), expanding on the work of Winnicott, proposed that the therapist's main function with children who are unable to play meaningfully and coherently should be to serve as an organizing, enhancing and engaging play partner. From her perspective, helping children to achieve the capacity for symbolic play is crucial to the therapist's role, precedes interpretation and, in some cases, should replace it. She writes 'We tend to think of our work as uncovering meaning, but I think that by learning to play we are helping children to make meaning.'

Hopkins (2002) emphasized Winnicott's view on the sequential development of play and the importance of naming – giving words to the child's feelings and thus making shared,

that which was private. She describes the process of discovering the self in relation to another, as the way in which baby games enable the child to think his own thoughts, work through his experiences and, generally, enjoy life.

Bion (1962) introduced the concept of containment. He described how a mother, faced with primitive projections from her baby, can absorb them, process them and feed back to the baby an experience which has meaning and is therefore more manageable. He writes of the dual role of this process: firstly, to settle the baby and make his emotions bearable, secondly to give him a model of a mind which can think about and manage feelings. The child is given the experience of another mind, which has been able to receive his preverbal and pre-symbolic communications, feel them and mentally digest them. He sees this as a model of how the mind acquires the capacity to have thoughts and think about them in way that is creative and meaningful. He emphasized that play could also take place with ideas. The opportunity to play with an interested person with a particular attitude, therefore, can be seen as a process of actively holding the baby's mental state and can serve as a containing experience.

Working in the neonatal intensive care unit

Many have written about the impact on babies and their families of the sudden birth of a premature baby (McFadyen 1994, Camhi 2005). Parents are often left feeling shocked, disorientated and disempowered. The painful and exhausting experience of visiting daily, waiting helplessly and frequently anticipating the worst deplete their capacity to believe in themselves. They also have to live out the most intimate moments and personal grief in the public space of the hospital and with relative strangers. Their state of mind can make them less accessible to the help available (Klauber 1998, McFadyen 1994).

Child psychotherapists working in this setting have had to adapt their style of work to accommodate the special needs of this vulnerable population (Vas Dias 1990, Emanuel *et al.* 1990). The work often referred to as applied psychotherapy, drawing on psychoanalytic theories and child development research, takes place by the incubator or cot on the unit. Using her understanding of unconscious processes and experience of close observation of infants, the child psychotherapist aims to help parents understand their babies' minimal communications and responses. She tries to bear the unprocessed and often unvoiced anxieties of baby, parent and staff, while deeply respecting the need for defences. She aims ultimately to facilitate the coming together of infant and family.

Rachel – our first meeting

In my role as clinical assistant to a Liaison Child Psychotherapy Service on NICU, I was asked to see Rachel, a baby girl aged 13 months (uncorrected age), and offer her an opportunity for stimulation and early learning through play. The play sessions took place twice weekly on NICU and lasted between 20 minutes and an hour and a half. On most occasions Rachel's mother was present.

Rachel was born at 27 weeks gestation. She was small and unwell for a very long period of time and suffered numerous medical setbacks. Her main difficulty was breathing without ventilation, and this persisted for a very long time, which compromised her growth and development. Eventually, aged nine months (uncorrected) Rachel had an operation for a tracheostomy to keep her airways open and help her to breathe. This operation was a success, but it meant that Rachel could utter no sounds as her voice-box (larynx) was affected by the tube which had been inserted into her trachea which by-passed the larynx.

Because of Rachel's significant and long-standing medical problems, which she had since birth, she remained in the high-dependency unit where she was constantly monitored. She was often very ill indeed and needed highly specialized nursing care. Due to severe chronic lung disease, she experienced several collapses and needed to be resuscitated many times. Her mother spent all day and every day at her cot-side and other family members visited whenever they could. It was a very lonely time for Rachel and her parents.

As well as not being able to make any sounds, Rachel was also unable to drink from a bottle or take food by a spoon. All her feeds went directly into her stomach through a gastrostomy, a feeding tube. This was not because she was not able to feed normally, but rather because the experience of taking food in through her mouth was associated with many episodes of choking or sudden collapses, making her fearful of anything entering her mouth, and resulting in a refusal to swallow. I wondered whether by protesting at the intake of any kind of food she was expressing her distress at having to adapt to 'the flavour' of different kinds of intervention and intrusion into her body.

I felt a measure of fear, shock and compassion on meeting Rachel for the first time. She lay floppily in her cot while being fed through a naso-gastric tube which was held by a nurse. She seemed a very large baby, compared to the other tiny ones needing an incubator, and she had her own large cot with toys and books that her family brought in. Rachel was unable to sit unaided and her trunk and limbs appeared frail and lacking in tone. Dressed in a pretty vest and trousers, Rachel lay propped up with cushions, looking vacantly around, seemingly distracted and uninterested in the nurse who stood next to her, holding the tube.

During a number of my early visits, I was struck by how immature she seemed and I suppose, for that reason, I instinctively thought of playing a peek-a-boo game with her. She seemed inhibited and overwhelmed by anxiety and appeared to be caught up in an endless, repetitive, almost ritualized game, which nevertheless seemed meaningful to her. This consisted of staring at her hand, as if by looking at it and hiding her face behind it she was trying to come to terms with emotional experiences of some kind.

Observation and play

Rachel at 13 months

Rachel was lying in her cot looking at her hand as if with admiration. I came closer to her and called her name softly. She looked at my face. She made her usual greeting expression, which looked as if she was going to blow a kiss. She waved her arms slightly to her side and kicked her feet several times in excitement. Her eyes were showing joyful surprise and were full of expectation. They seemed to be saying 'I recognize you'. I talked to her softly for a while, verbalizing her actions to her. She lifted her arms closer to her face then extended them, looking at the back of her hand with admiration and gave me another prolonged inquisitive look. I covered my face with my hands and said 'Rachel, peek-a-boo'. I separated my hands revealing my face to her. To my surprise, she did not look at my face at all but instead followed the back of my hand as it moved sideways and she gave it one of her prolonged looks instead. Puzzled by her response I repeated the game a few times and, each time, she 'rewarded' my hand with a prolonged look instead of my face.

While gently verbalizing her actions to her, I was beginning to wonder whether she was trying to communicate how unready she was to face the pain of yet another separation, even in a playful way. When my face disappeared she could not keep hold of it – but she was able to keep hold of her own hand. I wondered whether this was linked to long periods of

separation from her mother who, in spite of her dedicated commitment, could only stay with her during the day and went home each night.

The nursing staff reported to me that, at night time, she would often wake up and until they reached her, she sometimes resorted to hurting herself or pulling out her hair.

During her play sessions with me, Rachel's usual state of floppiness was contrasted with both her strong physical grip on my fingers and what I came to call her 'latching smile'. Despite her inability to talk, Rachel could fasten herself onto me with her smile in an attempt to prolong every possible moment with me, as if somehow for her there was not an internal holding and therefore it was very important for her to hang on to external objects.

As time passed, Rachel got used to the regularity of my two visits a week. She was able to demonstrate her unmistakable recognition of me by expecting with some certainty to play peek-a-boo with me and to become an active agent in the game. She turned this into a 'ritual' shortly after the onset of our sessions, colouring it with her own invented variations. Initially she would look away from me rapidly and then again towards me. While she was turning away, burying her head into her mother's chest, she seemed in an anticipatory mood as if 'spying' on me from the corner of one eye. There were also times when Rachel would suddenly 'lose interest' in me by seemingly showing an interest in a toy.

Rachel at 14 months

Rachel looked me straight in the eyes intensely for about a minute, gently lifting up her head and rocking herself on the chair or kicking her feet with excitement. I simply gazed back. She looked at me and then changed her typical long pout to a slow smile which started to play around her mouth. She then looked back briefly at the comb which she had placed right in front of her eyes by this stage. She quickly looked back at me for just a moment. She again looked at the comb and followed it with her eyes as she lifted it up and then away from her and then up again. I felt useless and forgotten. I could not talk or verbalize her actions to her, since the noise from the great number of staff and parents nearby at that time was far too loud.

While I was still looking at her, perplexed, quietly feeling 'dropped' and wondering what to do with myself, Rachel suddenly looked back at me widening her eyes. There was such intensity in her gaze, her mouth twitched and a wide smile enveloped first her mouth then her whole face. She tilted her head back, still looking at me, with her eyes crinkling at the corners and laughing silently. I found that moment very moving. I smiled back at her — overjoyed for her that I had 'stood fast' and that I was there to receive her gaze. Indeed I had not let her down. I had understood her game and thought she felt that way too. Those were extraordinarily powerful minutes of great intimacy amongst all that hubbub of people and machinery. I felt spellbound. She turned her head and looked away from me and at the comb for a much shorter while and then at me again. I asked her whether she was, once again, hiding from me. To which she smiled, looked back at me and then away again.

It seemed to me that she was showing me how quickly she felt 'out of sight, out of mind', how awful it felt to be 'dropped' and not to know what to make of it nor how long it would last. This reminded me of Freud's description of the infant's state of mind, when the baby:

'cannot as yet distinguish between temporary absence and permanent loss. As soon as it loses sight of its mother it behaves as if it were never going to see her again; and repeated consoling experiences to the contrary are necessary before it learns that her disappearance is usually followed by her reappearance.' (Freud 1920)

Rachel was primarily willing to play peek-a-boo with me when she was in control of the game. I was, then, the one left to feel what she was going through, albeit in playful way. It was as if on a more communicative and symbolic level, these 'safe' experiences with me were extending her ability to tolerate frustration and anxiety and to be able to trust and take in new experiences of external stimuli.

Rachel's variations of peek-a-boo seemed to test the boundaries of her control over my mind in different ways. She would suddenly turn away from me and 'pretend' to stare at her hand, laughing voicelessly in anticipation, spying on me with one eye. After I had said 'Ah, Rachel is hiding!' she would laugh even more and look back at me joyfully with a triumphant smile. She would then repeat the game over and over again. There were occasions when she would hold my hands by the thumbs while sitting on my lap and would initiate the game of peek-a-boo: continuing to hold my thumbs she would lift my hands in front of us both and 'hide' her face behind our hands. 'Where is Rachel hiding?' I would ask, to which she would lower our hands and appear, like a Jack-in-a-box, full of delightful facial expressions. It felt as if she had to test the permanence of my existence in many ways. Referring to such infant capacities, Klein states:

His repeated experiences of the external reality become the most important means of overcoming his persecutory and depressive anxieties. This, in my view, is reality-testing and underlies the process in adults which Freud has described as part of the work of mourning. (Klein 1952)

Shortly after my first visit, despite the fact that Rachel may well have been exposed to extreme disruptions and deprivation in her early environment, she was able to show me that she could develop a reasonably normal capacity to play. In particular, her initial 'unconventional' way of responding and her use of the game 'peek-a-boo' had drawn my attention to previously unknown frontiers of play that I was only now beginning to value. It seemed to me that Rachel had found a way of communicating with me through this game and that she was eagerly initiating it, only with me (according to her mother) at each of my visits. She had amazed me with her own variations of the game that would sometimes last an entire session. I was also pleased to note that, despite being severely tested by her physical difficulties and literally unable to utter a sound, Rachel used the symbolism of play as her means of non-verbal communication – one which improved considerably during the course of our relationship.

Peek-a-boo, holding and containment

In all of her ways of using peek-a-boo, Rachel would behave consistently in one respect: whilst hiding she would continue to hold on to me or to remain watchful at least with the corner of one eye as if to make sure that she was in control all the time.

My constant 'naming' of her actions, together with my sharing and identifying her emotions and even her ideas seemed gradually to have helped her begin to experience some initial relief. She was developing a capacity to face and express her feelings via symbolic play (Klein 1950, 1961, Hopkins 2002).

Through repeated experiences of my attending to and giving meaning to Rachel's play, I provided her with some containment (Bion 1962). I also attempted to offer her a 'facilitating environment' by sustained interest and acceptance of her activity (Winnicott 1965).

Although seemingly content with the regularity of my visits, I was often struck by how willingly Rachel would reach out with her arms and her whole body towards me and even more so with her gaze. It was also unbelievably engaging, as if she were using her eyes to grab hold of me, wanting to claim me just for herself and never let go? as if, were she to blink, I might 'disappear' as is demonstrated in the following extract.

Rachel at 17 months

Rachel sits comfortably facing me and waving her favourite rattle in front of her face. She puts one of the round balls like bells in her mouth and dribbles saliva, looking at me with a joyful expression. She drools all over the rattle while looking gently though boldly right into my eyes, as if searching for something inside my head. Mother talks to me and I turn my head towards her for a moment, and then return my gaze to Rachel. She was shaking the rattle more vigorously this time and suddenly let it go by her side. She did not look for it by turning her head towards the place where it had fallen, but instead, without losing eye contact with me, she found the rattle by feeling around the space with her fingers and then, when she stumbled across it, she lifted it up from the floor.

I felt as if she was looking for ways to keep me and have me only to herself, as if she was trying to seduce me into being an ideal playmate. By engaging me in such an intense way, she was showing me that she wanted my 'internal mental space' for her sole use, thus completely disengaging from her own mother, even though she was present and attentive. In the play, her mother was the one now to be left with the feelings of being 'dropped' and 'useless', faced with the same painful, unreliable, disappointing and frustrating every day reality as Rachel. This was painful to observe as I was also acutely aware of the pain that Rachel's mother experienced at these repeated separations. Rachel's reluctance to lose eye contact with me when she dropped a toy, in order to search for it, seemed to indicate the unavailability of a good object in her internal life. I was reminded of what a six-year-old patient of Melanie Klein's once said to her: 'Whenever the fairy mamma goes out of the room you never know if she won't come back all of a sudden as the bad mamma.' (Klein 1926)

Rachel may well have experienced the many changes in her environment as disruptive to the process of containment as described by Bion (1962). Bick (1987) wrote about the experience of being held in a primary emotional 'psychic skin' which is comparable to the physical skin which holds the parts of the body together. Developmental difficulties caused by too early a disruption may well have resulted in the feeling of fusion or oneness with the environment. Separation could then be experienced as catastrophic as expressed by Winnicott (1965).

Slowly my comments and descriptions began to provide Rachel with a possible explanation for the wide range of emotions that she was now able to express through her play, as well as the potential for us to think about and explore their meaning together. Alongside this, her defence mechanism of holding herself together by staring at her own hand had gradually been replaced by a more vital interest in exploring surroundings, her different toys and me. She also began to express even stronger preferences or dislikes towards certain toys and people. This can be seen in the following extract from a session when Rachel was 18-months-old:

Rachel held my hands by my fingers or thumbs really tightly during the entire session as if she wanted to ensure control over my presence. She dribbled saliva all over me and lifted her face and body closer and closer to mine remaining in continuous curious and friendly eye contact, as if she found me absolutely fascinating to the point where I found this embarrassing and giggled a little.

There was something powerful in this maintained gaze and with it, she seemed to try to reach out and hold on to me. It was as if she was trying to hypnotize or mesmerise me with one long charming look. It felt gentle but also open and vulnerable, a little like a deer's look, helpless but calm. I was talking to her softly, verbalising her actions as usual. While I was holding her, she reached for my hair and pulled it down and towards her for the first time in the six months work. I was surprised and pleased at the same time that she was more deliberate and forceful.

The feelings of hatred and rage with which she sometimes pulled my hair or my glasses, seemed more direct and were expressed alongside the more loving and spontaneous feelings with which she simultaneously burrowed her head into my neck as I cuddled her after she had requested to be picked up (as she did with her mother).

When it was time for me to leave, there was seemingly a flight away from me, denying any feeling of destruction and loss. She would usually 'leave' me first by avoiding eye contact as if she had completely switched off. She appeared very self-contained and not upset. As time passed, however, she was able to show me her sadness by a tearful soundless cry as I was about to leave.

It felt striking, however, that during such times she seemed to be denying dependence on her mother. However, it was clear that her mother's presence was essential for Rachel in order to provide a safe enough environment in which she was able to communicate and explore some of her anxieties and conflicts.

When her mother was unable to be present during some sessions, this state of mind, and particularly her holding gaze, were far more fragile, less intense and lasted for much shorter intervals of time. She would lose interest in almost everything and feel rather restless. It felt as if she were 'looking to hear' her mother's voice and the assurance that she was nearby. All her senses appeared to be heightened in the way that a blind person's are. It was as if, in her mother's absence, there was no 'right place' for her to be accommodated, protected or entertained.

Even when her mother was engaged in conversation with me, Rachel's usual behaviour and play was characterized by floppily lying around or by a flat engagement with a toy. Invariably, she reverted to her usual fixed stare at the back of her hand, or in repetitive behaviour of some other kind. This seemed to suggest how rapidly she felt dropped and how alluring it was to hold onto the back of her hand with her eyes instead. She entered her own psychic world since this was a safer place than her insecure external environment. This was apparent at bedtimes when she did not reach out for comforting cuddles from her mother, but instead, simply rocked herself to sleep. She seemed to have developed a strategy to cope in this institutional environment.

Her mother appeared perplexed and, possibly, disappointed yet the situation then enabled her to express her fears and some of her real concerns about possible delays and disabilities in her daughter's development. While listening to her, I involved Rachel in ordinary games. When Rachel was 19-months-old, I introduced some simple toys, such as a cup and sponge. We played games of dropping and retrieving (a more sophisticated version of peek-a-boo). I thought that her sudden and tearful distress at the dropping of the little cup in our simple game and her immediate playful response when I gave it back to her could be a good indication that she realized that things could be retrieved.

I was hoping to convey to her mother that although Rachel was an ill baby she could play with simple toys and enjoy herself and that perhaps she preferred this to using special educational toys.

Rachel was beginning to express her need to be held and contained by the consistency and structure of the sessions and the on-going commitment of her mother and myself to

them. As the sessions developed, so did our 'dialogue'. She felt at ease while using the language of play to communicate some of the things which she was coming to terms with and it seemed to me that the two of us had a 'special understanding'. Play seemed to enable Rachel to consolidate her understanding of our separate lives and the continuity of our sessions. I now felt there was a demonstration of her ability to think about and recognize me as well as to remember our games.

I had many rewarding experiences. Rachel's mother, encouraged by her response to the play sessions with me, subsequently showed interest in the meaning of her daughter's play. I hope that my interest in Rachel's play made her emotional states more transparent not only to her mother but also to the unit staff.

Concluding remarks

I have explored the therapeutic value of play with a hospitalized critically ill baby. I have tried to show that by acquiring the ability to play symbolically, Rachel gained the opportunity to work through and integrate some of her difficult experiences at a pace appropriate to her developmental age. I observed that this enabled her to explore aspects of her feelings and preoccupations and to become familiar with her physical and mental environment in a secure way. This unusual and unfamiliar environment proved to be a much greater challenge than I had anticipated. I found myself having to work publicly with something that was essentially private. However, by offering her my private 'mental' space, I was hoping to enable her to acquire a better sense of feeling 'contained' and understood in order that further development could take place. Rachel had shown that the experience of my sessions provided her with enough containment to develop her capacity to play. She seemed to have benefited primarily from the mere quality of my attentiveness and my attunement to her emotional predicament.

I was also able to learn that the game of peek-a-boo is much more than a pleasurable activity. Freud (1920) considered such a game to be motivated by the repetition compulsion, with the aim of mastering unresolved trauma. For Rachel, this game indicated a way in which she could manage repeated separations and strengthen an expectation of return.

From my experience I discovered that, in order to promote symbolic play in ill or traumatized children, the adult playing with them needs to be attuned to the child's sensitivities by being attentive, non-intrusive and ready to encourage the child's initiations. Through my play sessions with Rachel, I also learned to put greater value on time spent playing with my own thoughts and ideas about the conscious and unconscious meaning which underlie play in order to increase the possibility of a shared understanding that Rachel and I both nourished.

The work on the unit provided me with some first-hand experience of what it was like for these young children, during the early days after the traumatic event in their family. It also broadened my understanding of how play can be used clinically, not only to help children to develop their powers of communication, but also to learn to trust the therapeutic space as a place where one can safely explore and express difficulties.

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