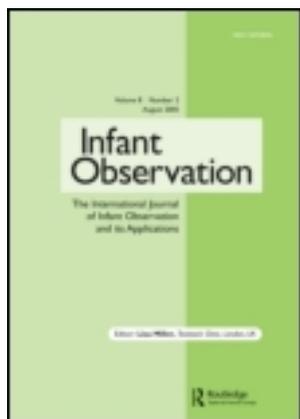


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On: 19 February 2013, At: 06:15

Publisher: Routledge

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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: 21 Aug 2006.

To cite this article: Annette Mendelsohn (2005): Recovering reverie: Using infant observation in interventions with traumatised mothers and their premature babies, *Infant Observation: International Journal of Infant Observation and Its Applications*, 8:3, 195-208

To link to this article: <http://dx.doi.org/10.1080/13698030500375693>

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Recovering reverie: Using infant observation in interventions with traumatised mothers and their premature babies

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Abstract

There is a danger in the subsequent days and weeks following premature birth that the traumatic impact on emerging maternal feelings will inhibit the mother's capacity for reverie (Bion 1962), steering her away from an experience of being with her baby. This deprives both mother and baby of opportunities to establish vital emotional links, thus further traumatising their developing relationship. In this paper, the premature baby's early experiences in neonatal intensive care and the efforts of mothers to interpret them and engage emotionally when they themselves are traumatised are explored. Using an applied method of observing the baby with the mother, the work of the child psychotherapist during the early critical period is discussed, showing how psychotherapeutic work provides a 'psychological nest', a mental space to facilitate emotional recovery and the de-inhibition of maternal reverie. Finally, with extended extracts from observations of a baby and her mother, where frozen reverie challenged an already compromised baby, I explore how observing in participation shed light on aspects of the emerging relationship and lent direction to the clinical intervention.

Keywords: *Premature baby, neonatal intensive care unit (NICU), traumatic impact, maternal reverie, infant observation, child psychotherapist, psychological nest*

Introduction

More than 20 years ago, Rolene Szur (1981), writing about the child psychotherapist's unique contribution to working with neonates in a hospital setting, drew attention to the value of using psychoanalytically informed infant observation to 'elucidate patterns of meaning' in the baby's behaviour. She described how this method, which combined the details and sequences of behaviour with a receptive and empathic attitude, drew thoughtful attention to emerging relationships. Indeed, it is the articulation of meaning through this method of observation that has become an essential part of the psychotherapeutic dialogue with parents and their babies in medical settings, and remains the corner-stone of applied psychotherapeutic work.

Making use of the method of infant observation in settings other than the family home for reasons apart from training has had its own evolution. In hospital liaison work, it has been used with very ill children at the bed-side (Judd 1989, Emanuel *et al.* 1990) generating a sensitivity to the child's experience of her illness and thus helping to inform the therapeutic

response. But it is in the neonatal intensive care unit (NICU) where psychodynamically informed infant observation has had a major relevance and has flourished as an invaluable therapeutic tool. Applied in this highly specialised hospital environment, focus of attention incorporates the baby's experience with the vicissitudes of maternal feelings and states of mind, illuminating the minute details of the baby's first attempts to communicate and the mother's attempts at recovery and reclamation of her baby. It is in this context that I consider the clinical role of observation in participation with mothers and their initially hard-to-reach premature babies. I focus, in particular, on the traumatic impact on maternal feelings, namely a capacity for maternal reverie (Bion 1962), re-iterating the contention of Klauber (1998) that the direction of effective psychotherapeutic work with traumatised parents is informed by a prior knowledge of the psychological effects of trauma. I explore how the nature of such a trauma provokes fearful and disabling interpretations of the baby's behaviour, thus endangering their developing relationship. The case material highlights the effectiveness of addressing the trauma therapeutically, supporting mothers to re-establish an essential connection with their baby.

Note: I am aware that my main focus in this paper is on the mother and baby, specifically the impact on maternal capacities. This is not to undermine the immense importance of the father's role and relationship to the mother and the baby. On the contrary, to give full significance to their role would require a separate paper.

The neonatal intensive care unit: The emotional impact

Winnicott's dictum that 'there is no such thing as a baby' but a baby in relation to its mother, has a particular poignancy on NICU (Winnicott 1960). For an observer, the rows of solitary babies in their incubators evoke a painful reminder of the loss of a healthy pregnancy and the ensuing separation of babies from their mothers. Parents who are all too often in a highly aroused state of concern or anxiety can be deeply affected by the visual impact. Other factors, such as the discomfort brought about by too much heat, the darkness, the smells and the lack of privacy on the unit, are often highlighted by parents, but the overwhelming sight of so many very small babies in incubators stands out as the most shocking feature and remains in the minds of parents long after they go home with their baby.

The neonatal intensive care unit is indeed a singularly strange and awesome place. It is a place where babies are living and growing, but it is singular and out-of-the-ordinary because it is manufactured and outside of the natural environment for the developing baby inside the uterus of its mother, which is not seen. There is a sense that one has entered forbidden territory, one ought not to be there, and one ought not to be looking. The unit is dimly lit and blankets cover the tops of the incubators. The babies are thus shielded from too much light, which over-stimulates them and causes them unnecessary stress. The babies inside their covered incubators are further obscured by the technological wiring which surrounds them, their heads covered in the smallest of woollen bonnets, their faces smothered in hard plastic or metal paraphernalia, their features squashed and unrecognisable. 'Rats in hats' was the way one shocked hospital porter described the premature babies when he visited the unit for the first time, unprepared for the visual and emotional impact.

Cohen (1995, 2003) affirms that it is the babies who lie at the heart of life on NICU, but also describes the difficulties the observer encounters in looking for them as well as finding ways to think about them, or find the language to articulate their pre-mature experience, so very different from those of the full-term newborn. This is related to the difficulty of holding onto the baby's raw experience in our minds, echoed by Lazar (1998) who likens such

observations to proto-experiences where thinking, reverie or recall of such incoherent experiences in the usual sense, seems hardly possible.

This is all the more stark and painful for a mother who, like the baby, is hardly prepared at all for the grim challenge of life outside the womb and at a loss as to how to make sense, not only of her baby's behaviour in the incubator, but also how to make sense of what has happened to her expected maternal responses. Overwhelmed with guilt, she may hear the unit's explanations for the required darkness in the unit with an irrational part of herself, not as protection for the baby, but as her punishment (Mendelsohn 2003). Sustaining her attention on her initially very tiny, disorientated and vulnerable baby who is at times confused not only with her own infantile-self but also with a harshly critical super-ego, may impel her to shut down on thinking and minimise her attempts to get to know her baby.

On seeing the baby for the first time

Mrs B's baby boy Karl was born at 27 weeks gestation. He was taken to NICU and some hours following the delivery Mr B went to see their son. On returning to his wife he told her the baby was fine, just very small. Re-assured, Mrs B was wheeled to the unit to see Karl the next morning. 'I looked at the baby and it wasn't just small, it was that I couldn't recognise him. I was so shocked, I asked to be taken back to the ward.'

In the early stages of his incubator life, Karl, born three months before term, looks red and wrinkled and he can be observed squirming and shifting his bony raw form as he struggles to get used to gravity and the heaviness of his pencil-like limbs, now weighed down by splints which keep the lines into his veins in place. On occasions, he appears to be slowly shifting himself about as if he were searching for points of contact or to grasp hold of something with a searching hand. This may be a tube from his breathing apparatus fixed in place around his nose, or a feeding cannula, a thin tube inserted into his mouth which goes directly into his stomach for his hourly expressed breast milk drip-feeds. At other times, he may be observed awake, eyes opening and closing, limbs stretching, fingers curling around his face, or he may be found in a very still, deep, post-birth nesting sleep which could last for several long hours.

Karl's skin is like flaky parchment, almost translucent. It gets sore and breaks easily. It can offer little in terms of protection at this stage, but the baby lies in a soft padded 'nest', rolls of foam tubing covered in towelling inside his incubator which binds him into a comfortable place to give him some sense of being contained. He makes huge movements as he stretches out an unsplinted arm over his head which then swoops gracefully across his face. He extends his arm again which falls by the side of his head and his fingers linger there, as if soothed by the contact. A tongue appears and his lips begin to make the tiniest of shapes as if stimulated by the touch, and triggers the first glimmer of a rooting response, the anticipated meeting of mouth with nipple.

Successive movements on his face burst out rapidly and unexpectedly. He winces, frowns, smiles, laughs and cries all in the space of a passing moment. He puckers his forehead, his cheeks quiver, his eyeballs move rapidly under his eyelids.

Fingers stretch and curl, open like a fan then close leaving a thumb or index finger stretched out like a small antenna. His chin jerks forward, feet flex and toes spread in different directions, he frowns and raises his eyebrows, his tongue protrudes, licks a plastic tube and disappears again, an eye opens and abruptly closes, the whole body stretches out and the cycle of movement begins again. Too much stimulation, sound, light, or handling, can disorient him to such an extent that

he becomes quickly exhausted, unable to focus and unable to find a way of holding himself together. Disorientated and suddenly disorganized, his distorted face crumples, he winces and starts to cry, his body shuddering and jerking as he attempts to find a focus or some kind of plug for his distress. His crying and moving may last no more than a few moments and he stops as abruptly as he began, appearing to have fallen into a deep sleep or perhaps to have shut-down, the experience of disorientation and an unmet need, too much for his immature system to manage alone.

First encounters with both the frailty and the inchoate nature of the baby's bodily state can be alarming for parents. As Mrs B described, it was not the size of the baby which shocked her, but the fact that she could not put together the baby she had come to know growing inside her, with what she saw in the incubator; she was unable to recognise him as her baby.

Trauma of prematurity and its effects on the capacity for maternal reverie

The traumatic impact of having a premature baby weaves an intricate pattern of progressive insults to mothers and babies alike (Mendelsohn 2002). This is re-iterated by Cohen (2003) who has also shown how the traumatic impact on the mother dismantles her capacity to think, which in turn may add a further stress to an already over-compromised baby.

Ernest Freud has talked about the terrible anguish experienced by mothers who 'haven't produced the right thing at the right time' (Freud 1981). A traumatic delivery when the baby is suddenly ejected from his natural growing place, where he has been dependent on the bodily functions of his mother for his growth and development, into a strange, alien environment where he is dependent on the functions of others to complete his growing, evokes feelings of self-blame and guilt which adds to the anguish. In spite of an ethos on NICU that advocates intimacy, there is a substantial difference between what is normal and ordinary for mothers and their newborns born at term and what circumstances are like for those who are not. In spite of every effort to console, to reassure, to ameliorate the harshness of the clinical environment by introducing more humane methods of care, for every new parent the anguish at the sudden rupture of a pregnancy and the precariousness of the baby's condition, pervades their minds.

Studies which have examined the responses of parents and the effects on their interaction with their babies in NICU have shown the intricate inter-relationship between the baby's condition, the ecology of the unit and parental perceptions (Minde *et al.* 1983). With sicker babies, mothers showed less smiling and touching behaviours and babies were less active and alert, both during visits to hospital and at six and at 12 weeks post-discharge. Parents may equally feel at a loss as to how much they should interact with their baby and some over-compensate for a perceived deficit by stimulating to excess. This can de-stabilise the baby even further.

Described by Bion (1962), the capacity for maternal reverie is what draws the mother to her baby with a curiosity to discover, decipher and respond to his needs with sensitivity to his emotional experience. Linked to his model of thinking, a capacity for maternal reverie implies mindfulness, the mother's mind acting as a container for the baby's feelings and experience. What is crucial about this model is more than emotional holding, and implies an emotional facility to bear the full impact of the baby's raw, indigestible experience, transforming these elements to make them more bearable for the baby. This capacity, I suggest, is profoundly challenged on NICU, leading to interactions as the research demonstrates which go affectively awry, out-of-tune with the needs of the baby.

The baby is jettisoned abruptly into a world for which he is barely prepared and his survival will depend upon medical intervention and close monitoring by medical specialists. Similarly for a mother, the maternal capacities required to welcome the new baby and take on the task of mothering, are barely mature, not having yet completed the last trimester of pregnancy where psychological preparation is at its maximum (Brazelton and Cramer 1991, Raphael-Leff 1991). The mother too will need help and support to discover and engage with her baby, and will be encouraged to do so by the nursing staff, yet the conflicting demands in her mind in response to the trauma she and her baby have endured and indeed continue to endure, make this task an arduous one, particularly in the initial period of the baby's hospitalisation.

The over-riding symptoms which closely resemble a post-traumatic stress disorder in this context are avoidance of traumatic reminders and hypervigilance. These two powerfully conflicting mental forces are those which may seriously interfere with a mother's attempts to get to know her baby and thus her capacity for reverie. She may feel compelled to avoid any reminders of her or her baby's predicament by staying away from the baby and the unit, if not literally then certainly in an emotional sense. Such traumatised mothers may visit their baby regularly yet seem distant or vague, sitting for a long time by the side of the baby's incubator as if in a daze. Some feel they have to force themselves to spend time with the baby, frightened by the fluctuations in their mental state, the intensity of their feelings and the fears and phantasies which these evoke. Most mothers will report disturbed sleep and many report having nightmares.

Directly opposing the overwhelming pull away from reminders of terror and helplessness, is the need to remain vigilant. An all-pervasive fear of death drives the traumatised mother to a 'glue-like-sticking' to the baby's incubator with a fearful preoccupation. With the thought that she has already endangered the baby's life, some mothers hardly dare to reach out to the baby in case he suffers more. Having to leave the baby to attend to her own needs or those of a husband or other children can seem like a terrible betrayal, and increases the guilt she feels in relation to the invasive medical procedures which the baby must endure. At another extreme, a mother may be so overwhelmed with a sense of euphoria that she and the baby have survived a terrifying ordeal, she can seem out of touch with the seriousness of the baby's condition and is easily distracted as if to keep other more troubling feelings at bay.

Affected in these ways, the traumatised mother may fail to notice or indeed observe crucial confirmation about the baby's individuality, how he behaves, what his needs are and how to meet them. The state of the baby as I described in the case of Karl, may often be labile and unfocussed, orientation and attempts at exploration hard to decipher because of their primitive nature and most importantly, because eye-contact is as yet uncoordinated, the baby obtaining sensory experience at this stage through hearing and touch. So that when the mother is psychologically absent as I have described, the baby is doubly traumatised, lacking the fundamental vitality of a life-sustaining maternal object. This can lead to a persisting 'unintegrated' state in the baby, described by O'Shaughnessy (2005) as a 'default position following from infantile trauma', which she contrasts with a normal situation when 'the infant's first object of knowledge (was) a psychological object – an embodied psychological object' (cited in Rhode and Urwin 2005). It is this default position I suggest which adds to the potential for further confusion about the baby's motives, a misinterpretation of his behaviour and the persisting traumatic impact on the emerging relationship.

Making a ‘psychological nest’

It is the nurses on NICU who provide the material of what is called a ‘nest’, a softly padded bounded container inside the incubator which gives the baby essential physical support and an experience of being physically contained. In a similar way, what I refer to as a psychological nest is a mental space provided by the psychotherapeutic dialogue in which psychological feelings and thoughts can be expressed, supported and contained. This equally essential support to the emerging relationship is facilitated by observation of the baby with his mother, encouraging her to re-engage with the baby, reclaim him and recover a capacity for reverie.

It is in this early stage following the birth of the baby that the need for an intervention afforded by observation in participation with mother is at its most critical. This is the time immediately following the birth when maternal anxieties and fears will be at their highest, influencing her perceptions of her baby and herself. These first encounters with mothers require a sensitivity to the moment and a free-floating attention. There is no prescribed agenda. I usually take a moment or two to introduce myself and explain what I do, then sitting or standing together by the side of the incubator, we may begin to watch the baby and start a conversation about him.

The precursors of early body-mind behaviours: response and receptivity to the baby’s language

Ms P was told when she came to visit her baby one morning that he had been awake during the night and had needed a lot of attention. At his incubator, Ms P found her baby asleep. She opened the port-hole and spoke to him, gently stroking his arm and hand, but the baby didn’t stir. Mother said later, ‘He’s ten days old now and I still haven’t seen him with his eyes open, but he was awake all night with the nurses. How will my baby ever know me?’

Nurses in neonatal care today are highly trained and experienced and they take time to show mothers how to carry out the task of nappy changing, washing, tube-feeding and careful handling of their tiny babies. It is often both because of and in spite of the capacities of the nurses to do their work so well that mothers find it hard to believe that their baby is theirs or indeed that their baby needs them. Intimately linked to this is the anxiety that the baby will not be able to distinguish his mother from all the other people who care for him.

The essential task of observing in participation with mothers is to address this fundamental question, to provide the evidence that the baby, in spite of his prematurity and apparently unintegrated state, is exploratory and very expressively seeking out responses from his world.

Rhode (1997) refers to modes of early communication as ‘statements of feeling’ in which the baby uses all sense modalities, i.e. movement of the body, the feet and hands, clasping or stroking to acquire information about the presence and expression of the mother. She goes on to say that, in turn, this offers the mother critical evidence about the pace and direction of information-seeking by the baby which facilitates further communication. Here Rhode is referring to early communication in the term baby but although behavioural sequences, activity and response are of a more primitive nature and of shorter duration in the premature baby, these communicative behaviours are no less relevant, but with responses from auditory and tactile stimulation often preceding the visual, as the following observation indicates.

Ashley born at 26 weeks. Observed with mother at 29 weeks

This is my third meeting with Ashley and her mother. When I arrive Ashley, well-wrapped in a blanket, is just being brought out of the incubator by a nurse.

She settles Ashley on mother's lap on a pillow and mother then draws her in towards her body, slipping her arm under and around her. The nurse adjusts Ashley's feeding tube which goes through her mouth and into her stomach, pours some milk into the syringe attached to the opening of the tube and gives it to mother to hold with her other hand. Mother's smile is radiant as she looks at Ashley who lies with her eyes closed, very still.

I sit down next to them. Mother is talking gently to her baby. Ashley's eyes open. Mother, delighted, increases her flow of talking. I wonder whether Ashley has been roused out of her sleep by the feel of her mother's body around her, the sound of her voice and the slow dripping of milk into her stomach. I notice that her eye balls are quivering and moving almost imperceptively about the eye. They seem unable to focus. Mother soothes her. 'So much happening all at once', I say. Mother tells me that Ashley had been asleep, then it was time for the feed. She questions whether or not Ashley is hungry, and decides that she is unsettled. We talk about whether several things following one after the other, startled Ashley; from sleep to being brought out of the incubator, held in mother's arms, and fed, all in just a moment or two. Ashley's arms are moving now and they break free of the blanket. Her hands appear and they curl around the edge. Her eyes are open but still unfocussed, eyeballs quivering and moving about in the same way as her fingers which seem to be more organised than her eyes. She seems to be exploring the edges of the blanket and I wonder with mother if she is trying to find her with her hands and fingers. Ashley's body stirs under the blanket and mother gives her a very gentle rocking. Ashley's eyes close suddenly. Under her eyelids, there seems to be so much movement, like the flutterings of a butterfly's wings. Her face puckers and two fingers on her left hand spring up and poke and push the blanket. Her other hand springs away and her fingers fan out at the same time as her mouth opens. Her mother has continued to smile at her, watching the activity with delight and she coos at her, praising her efforts. 'I think she feels hungry now', mother says to me. Ashley's eyes open again in the same way as before. They are still uncoordinated compared to the strong and purposeful movements in her hands and fingers. She appears to be using her fingers like antennae, feeling the air and drawing herself closer towards her mother's lilting cooing. Mother is unperturbed by Ashley's unfocussed eyes and becomes more animated each time Ashley's mouth opens. Quite suddenly, Ashley turns her head towards mother's body with an impressive rooting, as if everything has come together in anticipation of finding the nipple. Her mouth opens, making various shapes. Ashley continues to seek out with her mouth, as if trying to locate the breast. Mother talks to her telling her she understands what she wants. I volunteer to find her dummy to suck on so that her efforts can at least be partially realised. Sighs of relief from mother when I take over the holding of the tube, leaving her a hand free to hold Ashley's dummy and coax it into her mouth. As Ashley takes the dummy, she brings her now closed hands up towards the sides of her face, drawing her body up at the same time. She takes a few small sucks and her eyes close.

This example demonstrates how mother and baby are both active participants in efforts to organise bodily sensations and co-ordinate each successive link in a pattern of meaningful behaviours. These attempts to integrate statements of feeling (Rhode 1997) bring the baby into bodily and affective contact with mother. There is a strong sense in which mother's presence in mind and body allow her to patiently reflect on the baby's efforts and intuit her intentions. This further corresponds to what Rhode proposes as the 'integration of sensation and meaning' and the coming together of 'mental and physical experience'. For

Ashley at 11 weeks before term, it was not the visual contact that assumed primacy, eye integration and focus as yet too immature. Rather a chain of sensation–response behaviours facilitated and confirmed by mother’s empathic holding, gradually enabling the definition of the baby’s body, arousal of an expectation, and an ensuing search for a focus which brought an eventual realisation.

Ashley’s eyes, whilst perhaps stimulated by her desire to look and find, seemed at this stage of her development more effective in acting as shutters to block out too much sensation, a kind of self-regulating time-out procedure which allowed her a few seconds to regain herself, set off and try again. Her mother was able to tolerate her baby’s immature visual apparatus, and remained sensitive to the baby’s responses through other sensory modalities. She seemed also to be able to empathise with her baby and the efforts it was taking to engage even for such a short period. But, for a traumatised mother still struggling with frozen reverie and a premature baby whose visual apparatus is immature and unintegrated with other senses, the baby’s behaviour may be perceived as persecutory and rejecting.

The recovery and reclamation of Alice born at 30 weeks gestation

I come now to a case study that describes the early post-birth period for a mother and baby on NICU where an aesthetic conflict played a significant part in the freezing of maternal reverie. This particular mother and her second baby Alice, brought to mind Meltzer’s example of a mother with a brain-damaged child who had been unable to look at her as ‘her ordinary beautiful baby’ (cited by Williams 2000). This stymied the unfolding of aesthetic reciprocity, leaving the child with no impetus for curiosity, no light in the mother’s eyes to discover. It was similar with this referral. Alice’s mother was described as an enigma by the staff. Seemingly caring, experienced, and coming in to visit everyday, she was nevertheless seen to be recoiling from her baby, spending little time with her and leaving the unit often in a hurry. Alice, born prematurely because of her lack of progress *in utero* and found to have a number of medical complications which required treatment elsewhere for a period of time, appeared to be as puzzling. She too seemed to be disengaged, lying lifeless and alone in her cot, rarely awake and unresponsive, and still requiring a little oxygen to help with her breathing and having to be tube fed in spite of the fact that she was almost at term and medically improved.

I was asked by the nursing staff to see mother because of concerns raised about her mental state, and simultaneously, the paediatric occupational therapist was asked to see Alice, to assess her developmental progress using the Neonatal Behavioural Assessment Scale (NBAS), (Brazelton 1995). We both agreed to take on the referral but to work separately, agreeing to meet to confer and monitor any progress. Before I move on to describe the material, some description regarding the NBAS is necessary.

The scale developed by Brazelton in 1970 was one of the first assessment tools designed to demonstrate a range of abilities and functional behaviours in the newborn: the capacity for behavioural orientation and self-regulation as well as a repertoire of demonstrably purposeful socially interactive behaviours. The scale is based on the premise that infants are highly capable, complexly organised social beings and its clinical value lies in the opportunity it offers parents to engage actively in the observation of their baby and share perceptions. There are many obvious similarities with the method of infant observation in participation used by child psychotherapists as I have already described, the key element being the shared observations of the baby’s behaviours with parent(s) to enhance their understanding of the baby. Used in parallel with psychoanalytically informed observation,

in which a major consideration is the unconscious elements in mother–baby interaction, a bridge between internal and external worlds can be created. This is particularly effective in the work with traumatised parents on NICU who often need hard evidence of the baby’s potential to help them distinguish between reality and a fantasy of irrevocable or inestimable damage (Klauber 1998). I will return to the effectiveness of a combined approach later in the discussion.

The brief work I undertook with Alice and her mother began when she was 34 weeks gestational age. Soon after Alice’s birth at 30 weeks, she was transferred to another hospital for investigations and later some surgery. She recovered well, but her return to the hospital coincided with a holiday period and I did not hear about her until I returned. These are my first impressions:

I find Alice lying in a transparent perspex cot in the low-dependency nursery. She is very small and barely visible. She is lying on her left side covered by a pale blue hospital blanket which is neatly tucked in at the sides. I see the bare outline of her very still form. I cannot see her arms or hands, and her head, covered by a blue knitted bonnet is barely visible above the blanket. I see a very pale cheek and a closed eye. There is no movement under her eye-lids. Her mouth is closed and absolutely still. I am distracted by noticing that there are no toys or personal items in or around her cot, and I note how unusual that is for a baby at this age. Alice remains motionless and deeply asleep. I stand and watch her alone for ten minutes.

A week later I hoped to find mother for our first meeting which had been arranged by one of the nurses.

Mother doesn’t arrive and I am told she left a message to say she wasn’t able to come that morning. I decide to observe Alice on my own again and stay for another ten minutes or so. I discern no change from a week ago. She lies crisply tucked up in blue, hidden as before. I can’t make her out. I consider whether or not to lift the blanket a little to see her more closely but for some reason I decide not to. A nurse joins me and tells me that Alice is still being tube fed and still requiring oxygen. She adds, ‘Alice isn’t really doing very much at all’.

I was struck later as I wrote my notes, by Alice’s invisibility and lifelessness. It made me wonder about my own lack of inclination to spend more time looking for her. I was reminded in this instance of the thoughts of Cohen (1995) about observing a baby in isolation, that is without the baby’s mother being present. She points out that without the ‘mediating presence’ of the mother, seeing the baby, discovering her uniqueness, or finding meaning in her behaviour is problematic and indeed painful for the observer. With this in mind, I wondered whether the reason for my not having lifted the blanket to see Alice more clearly was linked to what the nurses had said about mother’s partial absence, or more specifically, her not visiting enough. Was it that Alice was a ‘not-doing-very-much-baby’ that was keeping her mother away?

I met mother for the first time a few days later. The previous day, she had been approached by my colleague who invited her for the first NBAS. Mother had refused to participate and my colleague was left to carry out the first of these sessions with just the baby. This she told me later was very unusual.

Mother looked tired and pale and was unsmiling when I asked her where she would prefer to be for our first meeting, with Alice in the nursery or in a side room? As with my colleague, she said she would prefer to see me without Alice. She began immediately we were seated, to tell me how

awful the last few weeks had been. She said she never thought that this could happen, there seemed to be so many things wrong. There were still tests to be done. 'Alice may have to go home on oxygen' she said, and she added that she hadn't expected that. She went on to tell me that her other child had been born at term and was perfectly healthy; this was not at all what she had expected.

I talked to her about her frustration and her deeply felt disappointment. She agreed, yes she was very frustrated, 'Alice is sleepy all the time, she is so unresponsive,' she told me. Mother went on to say she wanted to breast feed but Alice didn't know what to do so she had to have all her feeds by tube. Mother complained that no one could tell her what was wrong with her baby and she worried about the future. 'How do I know whether she will be all right?' she asked me angrily. Mother told me about her pregnancy, how well everything had gone and how much they had been looking forward to a new addition to the family. It came as a shock to hear that there was a concern that Alice may not be developing or growing as she should and that she would have to be delivered before term. As she spoke, conveying so much pent-up distress and frustration, I felt she was also making a huge effort to keep under control a bitter displeasure and a profound disappointment in her baby. I spoke to her about how not knowing what to do made her feel so helpless and at a loss with this unexpected feeling. She agreed and said angrily that she had never expected to feel so rejected by her new baby. I wondered with her whether these feelings of such disappointment and bewilderment were keeping her in a state of 'not-knowing' Alice, and whether Alice too was at a loss as to how to seek out and find her mother. I went on to say that it seemed as if a shadow had been cast over them, obscuring one from the other. Mother looked at me very intently as I spoke. Following these comments, she broke down and wept.

A few days later the second NBAS was carried out. This time, mother had agreed to attend and I was told that she had responded well to the session. It was the 'social interaction' that mother was particularly pleased with, when Alice demonstrated that she could focus her eyes on her mother's face.

The following is an extract of the second session I had with her and Alice aged 37 weeks.

Second session

I found mother seated in a large chair with Alice in her arms. It was unusually quiet, the doctors having just left to continue the ward round in another area. Mother smiled at me when she saw me and indicated that she wanted me to sit with her. I positioned my chair not too close but close enough to be able to see Alice clearly. She was lying with the front of her body against her mother's, at her left breast. Her eyes were closed and I noticed a very small sucking movement in her left cheek. At the same time her head bobbed very slightly backwards and forwards. Her body lay quite still, one leg softly resting on top of the other and her left arm and hand partially obscured, nestling softly between mother's breasts. Mother lifted her T-shirt to show me the small closed hand there and smiled. Alice was sucking gently and sleepily.

I remarked on these observable changes. I added that when I had observed her on her own two weeks previously, Alice had seemed like a 'not-ready-to-be-born' baby, not ready yet to interact with the world, and this had filled her with a fear that something was terribly wrong. I noted also that mother herself had changed. I wondered with her about this. Mother agreed, 'Alice is changing'. She apologised for having been so upset the previous meeting. 'I just had to tell someone and it all came pouring out!' she said. She went on to say that she was beginning to feel much better and that this was the first time Alice had been at the breast for so long, it was such a relief. I said I thought that they had found each other, and perhaps it was through the experience

of the breast-feeding that only she could provide that at last they could get to know each other. I pointed out that Alice seemed to want to wake up a little more and becoming more active in her efforts to get to know her mother. I added how helpful it had been for Alice that mother had been there.

Third session

When I arrived, I found mother in a side room with Alice, now 38 weeks gestational age. Mother had been rooming-in, spending all day and all night with the baby to establish breast-feeding. They were curled up together on the bed by the window. Mother was looking well and Alice seems to be absorbed in the feed.

Mother tells me she has been feeding for about 20 minutes. She explains that Alice was coming off the breast at times and still needed the occasional top-up by tube. As she speaks, Alice becomes unstuck, her mouth on the nipple one minute then open but empty the next. They just came apart. Mother looks at her for a moment. Alice is quite still, her eyes closed, her mouth slightly open and an expression on her face which seemed to suggest that she hadn't quite registered that what had been in her mouth was no longer there. I thought maybe that Alice was sensitive to our talking which had perhaps interrupted her. Mother pauses and then puts Alice back to the breast, gently easing the nipple into her mouth. She talks to her a little saying, 'You're not quite sure yet.' We talk about Alice's need for direction from her mother to re-connect with the breast and that the breast seemed to have become Alice's vital link to her.

After a moment or two, Alice comes off the breast again, this time a little more purposefully. Mother lifts her off the breast and places her on her lap facing me. I remark on this, suggesting that perhaps she didn't quite trust her own eyes yet and that the impressions of Alice via my colleague and me were still very important to her. She agrees and says how pleased she was when Alice looked at her. She thought that Alice was indeed beginning to learn things.

Alice's eyes were closed, and one side of her face looked squashed and red where she had been lying pressed up against her mother's breast. Alice spreads out her fingers stiffly, and her head flops over to the side. Her hands become busier and with fingers spread she lifts her hands up towards her face. She squirms a little. Mother observes this silently but thoughtfully and then bends down to kiss her head. She turns Alice around and cradles her. She asked her affectionately what was wrong. Was she still hungry? Was she tired? Did she have a tummy ache? She looks at her intently.

Alice began puffing again, breathing rapidly and quite heavily. It was a timely reminder of how strenuous this feed might have been for her and how critical it was for mother to be able to tolerate the baby's expressions of fatigue and her need for recovery and reintegration. We talk about this for some time, linking the baby's still sensitive and vulnerable state to an awareness of how easily this can turn into overwhelming fears about the baby's future progress. Observing Alice as she began to settle in her mother's arms, breathing deeply and with fingers moving rhythmically and drawing in towards her chest, she appeared satiated, a relaxed calm spreading over her face conveying a feeling of well-being, of being safely and comfortably held not only in mother's arms but also in her mind.

Discussion: On reclaiming Alice

I want to begin by drawing attention to what mother repeatedly told me during our first meeting, that Alice was not the baby she expected to have. And there were other blows which were painful. She anticipated that there would be no problems with feeding, and there were plenty. She expected her baby to be engaging, instead she complained that Alice was sleepy, unresponsive and showing no interest in the breast. In her debilitated and distressed state, mother perceived her 'not-yet quite-in-the-world' baby as far from all right and indeed the discordance between the baby she had expected whilst she was pregnant and her actual baby was so shocking to her that initially, meaningful engagement was unrewarding for both of them.

Stern (1998) explores several studies that examine representations of the baby in phantasy during pregnancy, and cites both Brazelton (1993) and a study by Ammaniti (1992). Both of these draw attention to the first stages of pregnancy when representations of the baby begin to grow in the mother's mind. These become quite elaborate and peak by the seventh month. From then until birth the phantasy of the baby-to-be lessens as the mother begins to prepare herself for the birth and a more realistic appraisal of who her baby is. This suggests that following a premature birth there may be a greater potential for discordance between the imagined baby and the actual baby. Alice was born at 30 weeks, perhaps at the height of an idealisation in her mother's mind.

This predicament is elaborated by Birksted-Breen (2000) who suggests that childbirth brings about several losses, one of these is the loss of the phantasy baby in favour of the actual baby and another is the loss of the 'phantasy self-as-mother', an idealised state where no mistakes are ever made. Such phantasies become all the more potent when the baby is born prematurely and when the need for medical intervention 'saps her confidence' in her own mothering abilities, '*which she feels* are not sufficient to keep her baby alive or to keep destructive forces at bay.' (my italics)

Reality threw mother into a state of shock and avoidance. In this traumatised state she was unable to allow herself a moment of reverie which might have enabled her to be more available to draw Alice out of her own frozen encapsulation, a passivity that mother subsequently misinterpreted. A possible hypothesis then to Alice's sleepy indifference to the world or passive unintegrated state as described earlier by O'Shaughnessy, may be that it was indeed a response to the absence of a maternal focus which would have served to hold the baby in mind with her 'ordinary devoted interest' (Winnicott 1988). The work that Alice had to do was made harder and perhaps took that much longer while the emotional link with her mother, that anticipated communication, was temporarily out of action.

So much in the early experience of the newborn is communicated and learned through the eyes, the visual impact of mutual gazing back and forth between mother and baby playing such a major role. Yet for Alice's mother looking at her baby was highly charged with anxiety. Her gaze not one of enquiry, intimacy or empathic contact (Stern 1990), but rather an act of scrutiny implying something critical or looking for what has gone or might go wrong with the baby (Sorenson 1999). In mother's mind it was Alice who was the agent of rejection, her passivity interpreted as punishment for all that had gone wrong with the pregnancy and birth. Perhaps this is what she saw whenever she looked at her inert baby.

Mother responded with distress when I suggested that the unexpected feelings of bewilderment and helplessness had prevented her from discovering Alice. Yet addressing her avoidance enabled her to start thinking of her not so much as a disappointment, but as a baby who needed her mother to start making the necessary enquiries into her behaviour. With this growing interest in mind, mother could begin attempting her own observations of

Alice, gradually recover, and gain a capacity for maternal reverie. This gradual de-inhibition of mother's capacity to engage with her newborn was assisted by the two-pronged approach adopted by the NBAS and the psychotherapeutic observational work.

During the third NBAS session, Alice demonstrated obvious visual responses to the presence of her mother. This was particularly in evidence when Alice showed she could focus on her mother's face with a lively alertness, another vital sign for this mother that her baby was responding to her. Ayers (2003) suggests that the eyes have been designed by evolution to seek out the eyes of the mother and that her gaze is the infant's primordial desire. She suggests further that it is through the visual encounter that the mother's presence as a psychological centre of the relationship is constructed. She cites Stern who talks about an 'eye world', a place where the infant in his highly vulnerable and dependent state has a direct, albeit unconscious line to what the mother is thinking and feeling through the intimate eye contact. This visual line of communication between Alice and her mother had been temporarily impaired, but it is noteworthy that for this mother and baby, what preceded a mutual eye gazing, appeared to be the focus on the nipple as the relationship to the breast increased, suggesting perhaps a precursor to the eye world Stern talks about.

This was observed during the two sessions where Alice fed at the breast and where mother was able to observe and interpret her baby's behaviour with a marked increase in sensitivity. Here we could observe their reciprocal efforts; Alice still a little tenuous and making huge efforts to make the essential links between parts of herself and parts of her mother. Mother warmly engaged with her attempts, being guided by Alice and helping her to organise her bodily sensations, giving her a sense of bodily integrity. There was a change in both. Mother was very much in effective and empathic contact with her, and sensitive to move at a pace that Alice herself set.

Here was the evidence for which her mother had been so desperate, but that in her traumatised state she had misperceived and misunderstood, that her holding, touching, meaning-giving talk and sensitive encouragement would elicit life-seeking behaviours in her baby and would be recognised as such.

Concluding remarks

Not all mothers are traumatised by the experience of having a premature baby. Mothers will respond in various ways and this will depend on many differing aspects of their internal and external worlds. However, I would agree with Cohen (2003) here, that most premature babies are traumatised and that their behaviours may be misinterpreted or avoided by those mothers who in a bewildered and shocked state of mind, are unable to reach out to their baby or attend emotionally to his needs. In this paper the focus has been on how trauma to maternal feelings might manifest, particularly on the capacity for maternal reverie which I suggest compromises the relationship, leaving the baby in a persisting unintegrated state.

I have argued that this requires the intervention of a mediator using psychoanalytically informed observation of the baby in participation with mothers who, in spite of being profoundly challenged by the baby's immaturity, can be enabled to watch, enquire and reciprocate with finely-tuned sensitivity the attempts of their tiny fragile infants to co-ordinate the very beginnings of their communicative behaviours. These are the early mutual body-mind behaviours in the proto experiences of premature babies whose eyes may as yet be unfocussed, but for whom maternal reverie encompassing the first visual encounters, can provide a 'way of being with' (Stern 1985), which facilitates some shaping of the baby's first efforts.

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