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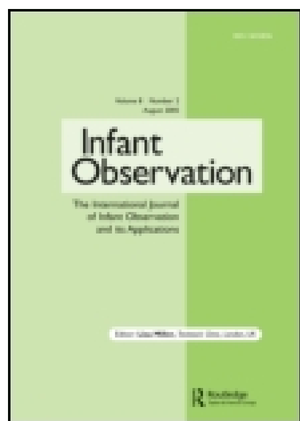

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Siblings of premature babies: Thinking about their experience

CLAUDIA CAMHI

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Abstract
This paper describes work with siblings on a neonatal intensive care unit. It focuses on the often unseen needs of the brothers and sisters of very ill babies. Informed by psychoanalytic theory, the writer explores, through observation, what the siblings make of their experience and offers a therapeutic intervention through play.

Keywords: *Siblings, under-fives, premature babies, neonatal intensive care unit, therapeutic play*

> *'The more I learn about sibling relationships, the more impressed I am with what ambivalent relationships they are, even when there is no illness or disability. It seems that when they are present, the ambivalence only gets stronger, the highs are higher... and the lows are lower. The challenge I suppose is to celebrate the insights and sensitivity one gains as a result of the relationship, learn the lessons from the frustrations and then, somehow, move on.' (Fleitas 2000 p. 268)*

Introduction

The above quote is from a parent voicing his impressions on sibling relationships when these relationships are challenged by illness or handicap in one of the children. He puts a complex experience into words. However, no matter how sensitive this adult is, nothing can really equal the first hand communications of a child talking about himself.

For two years, I took part in a project in the neonatal unit of a North London teaching hospital. The project was organised and supervised by a child psychotherapist. My function was to address the psychological needs of the families who had a premature baby in the unit with a particular focus on the young siblings. While working in the unit, I had the opportunity to explore what this experience was like for young children, during the early days, following the premature birth of their brother or sister. These children 'spoke' through their play and behaviour. This made it possible for me to learn how different issues regarding their own developmental stage and the whole of the new family situation troubled them. I was surprised to notice how eager the siblings were to use the time and opportunity offered by play as a way of working through or communicating their experience. This

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heightened my interest in exploring and thinking about the ways in which their experience was different from just having a newly born baby brother or sister.

There is little research on siblings of premature babies and the existing research on siblings of ill children tends to be retrospective and explore older siblings who are able to communicate verbally. The researchers generally use methods that give account of the siblings' behaviour, conscious thoughts and phantasies provided by self-report or interview techniques that involve the children or the parents. Even though this kind of research yields interesting results, it does not give an account of the flavour of these children's preoccupations at the time of a family crisis.

In this paper, I intend to explore, through the observation of behaviour and the use of play as a therapeutic opportunity, the phantasies of some siblings of premature babies. I will try to identify if there is something particular or shared by this group that differs from what theory describes as typical sibling phantasies. I will begin by reviewing the literature on the subject and then discuss the different themes with which the siblings were preoccupied.

The siblings I discuss are five boys and five girls, aged between 20 months and six years. All were the youngest in the family prior to the birth of the baby.

The temperament, the past and present experience and family situation of each child I met were unique. However, I think that there are certain themes that can be inferred from the play and my counter transference in the play situation. These might be of use to professionals working with young children in a similar situation and to those in charge of organising family support systems in hospital settings and follow-up support after the discharge of the baby.

Much of what I observed were brief encounters that give a momentary account of these children's experiences and 'internal worlds' during the very early days after the birth of the premature baby. These encounters do not tell us of processes regarding an ongoing sibling relationship, but it is important as a first attempt to explore the inner world of very young children exposed to an experience that is becoming more common–having a newborn in intensive care. It may also help us to think about some particular and complex aspects of relationships that are supposed to last a lifetime. Finally, it may help to think about the importance of supporting the siblings of ill children who may become the unseen members of the family at a time of crisis.

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Theoretical framework

The theoretical framework considers different factors and points of view that should help the understanding of the siblings' experience. I will briefly consider the concepts of trauma, traumatic event and institutional dynamics as factors that might have influenced the siblings. The material shown by these children will be discussed in the light of Klein's concept of inner world and mental positions. The role of play as a vehicle of communication and its other different functions will also be reviewed. The research findings on the dynamics of sibling relationships among ill children and the dynamics of well sibling relationships will serve as reference points to analyse the themes of this particular group of children.

Premature birth and trauma

The birth of a premature baby in the family can be thought of as a traumatic event for the parents and a potential traumatic event for the siblings. It is usually sudden and unexpected, tending to break the predictability of the child's world and its family. Parents

are usually worried and shocked, many show similar symptoms to people diagnosed with post-traumatic stress disorder. They may also be worn out by the long hours, days and even months they have to be with their baby in a neonatal unit.

The parents of a premature baby might be experiencing acute anxiety, increased arousal and states of denial. They might suffer from emotional numbness, psychological and physiological distress. They could also be beginning a grieving process for the loss of the normal pregnancy, birth and baby. The trauma that could be produced by the premature birth situation might affect their parenting skills, thus making the parents, for a period of time, emotionally less resourceful and available to their newborn baby and their other children and less able to make use of any help offered (Klauber 1998, McFadyen 1994).

Garland explains that a traumatic event is:

> *'a crucial moment in which anxieties coincide: the external event is perceived as confirming the worst of the internal fears and phantasies in particular the reality... the imminence of death... the failure of good objects to provide protection from the worst... the internal good object, that one believed one might turn to for protection or for help has been revealed to be careless or unconcerned or worse malignant.' (Garland 1998 p. 11)*

For the sibling, the premature birth has the potential to be experienced as traumatic, acting as confirmation of primitive anxieties. Some of these anxieties are related to the cruelty and strength of the bad internal objects; the fear of the loss of the good objects and the doubt in the ability of the child's own reparative capacities and goodness. The existence of an ill and tiny baby, that at times does not even have a human-like appearance, might act as a confirmation, for the sibling, that it was him, through his thoughts, phantasies and feelings who concretely damaged the baby, stopped it from coming home or actually killed it.

It is possible to think that the reverse is also true. The birth of a healthy baby might stir in the sibling all kinds of Oedipal tensions, sexual phantasies, envy and jealousy, but it also reassures the child that he is not omnipotently destructive and that his good internal and external objects are strong and enduring. The healthy baby is proof that mother has other loves and relationships but it is also proof that her ability to create good things is intact (Klein 1945). In this way the child can mentally take in and keep a healthy, human-like live baby who could act as a menacing rival but, who is definitely less conflictive than carrying in his mind a damaged or dead baby. The internalised damaged baby carries the child's own destructive unmodulated feelings and can be experienced as a very angry, frightening and persecuting baby. Children experiencing this might consciously or unconsciously believe they tend to destroy good things, fear broken or damaged objects, believe in their own omnipotent destructive capacities for killing what they need, search desperately for a missing 'something', check anxiously for signs of damage done by 'someone else'. They might also long for a merged state with their good object. This good object is usually the mental representative of a good internal parent. In this state, any separation, autonomy, sense of loss and need for the object is either denied or produces catastrophic feelings expressed in emotional cut off or breakdowns. Some children may have phantasies of omnipotently controlling and invading their good object, in order to avoid separation and loss (Mendelsohn 1992, 1997). For a time these defences might keep painful emotions at bay, but they might also seriously impair the child's mental development by inhibiting creative and integrative processes due to the excessive use of the defences (Klein 1945).

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Parental and institutional anxieties and their influence on the siblings

It is important to think briefly about what these children carry that does not necessarily originate in their internal world but becomes part of it through the projections of others. The possibly traumatised parents and the staff might have used the siblings as a way to ease their own anxiety and communicate intolerable and unprocessed experiences (Klauber 1998). Williams (1997) describes these kinds of projections as 'foreign bodies'. This means that parents and the people working in institutions might tend to get rid of their conflicting feelings and tendencies and perceive them as originating from the siblings. Therefore, these children can be carrying the potentially damaging feelings that adults will not allow themselves to feel for a very fragile baby or for each other. These processes might have influenced the play and behaviour of the siblings I observed in the neonatal unit.

Some psychotherapists have focused their studies on the way institutions and their members handle stress and pain. Menzies (in Judd 1995) understood that the system protected itself by establishing part object relations to the patients. This means relating mainly to the illness, body part, body function or treatment instead of the whole person. This allows the person to be able to carry on painful medical procedures and avoid contact with the anger the patients might feel towards them, the anger and disgust they might feel towards the patients and the emotional pain both are subjected to. The rotation system prevents workers from developing strong attachments with the patients. Spending time focusing on other issues can be seen as a waste of resources or interference with the task. The hands-on efficient life-saving procedures are at the core of the job identity; the rest is valued as an expensive luxury. These ways of functioning tend to become habitual and unconsciously seep through, influencing even the newcomers. The problem with these defences is that they might work in the short-term to facilitate a stressful and vital task, but in the long run they affect the well-being and mental health of the staff, the patients and their families (Judd 1995).

Halton (1994) describes how different groups relate to each other using projective mechanisms to relieve themselves of anxiety provoking issues. In the same line of thought, Cohn (1994) describes her work in a neonatal unit and shows how difficult it was to overcome the suspicion generated by observing, thinking and listening instead of doing things. That different role led her to be associated with the potentially damaging aspects of other workers and parents. Some of the recipients of these projections might also be the brothers and sisters I want to discuss. They neither have a specific practical role nor space in the unit.

Psychotherapists working in hospital settings have described how they have had to adjust their technique to be able to help in such a context by the use of applied psychotherapy (Vas Dias 1990, Emmanuel *et al*. 1990). Issues such as regularity, frequency and duration of the encounters with the patients had to be flexibly modified to suit the interdisciplinary hospital environment allowing for less defined boundaries, privacy and intimacy. They understand that the stable factor is the therapist, and his attention to the child and the family, trying to understand their inner world and the way it affects their behaviour and relationships. They recognise that the fundamental factor consists of validating the child's emotional experience in all its complexity. Validation is understood as:

> *'the process in which the therapist, by the use of his capacity for empathy and understanding of unconscious processes, is able to identify, acknowledge, listen to, receive and confirm the child's emotional experience. In this way the child's self is confirmed as true.' (Vas Dias 1990)*

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Emmanuel *et al*. (1990) add the need to respect defences in a context where catastrophic anxiety is present. They describe the therapeutic task as naming the unnameable, bearing the unbearable and mentioning the unmentionable.

Play and its different functions for the siblings

Freud (1920) was one of the first in this field to observe play and think about it psychoanalytically. He noticed the serious involvement of his 18-month-old grandson making a cotton reel appear and disappear. He thought that his play was a way of dealing with the mother's absence. It was also a way in which the boy was in control instead of being at the mercy of the mother's comings and goings. Freud understood the play as a way of negotiating between the frustration of the unmet need and the reality of the absence. He considered the possibility of play as a developmental progress (Alvarez and Phillips 1998).

Melanie Klein developed, by using play, a technique for child psychoanalysis. She thought of play as the means of expression of unconscious phantasy, which was in turn the mental representative of the impulses. The toys she provided for the children to play with served as the vocabulary for expression as words, free association and dreams would do for adults (Klein 1929, Hoxter 1991). Klein thought that projective processes present in play and personification allowed the child to communicate his inner world. With the help of the analyst, this inner world could be understood and modified.

For the first child analysts, play was a means of expression of the unconscious and carried a meaning to be discovered and worked through by making it conscious. The therapeutic value of play relied on the repeated interpretation the analyst made of the transference situation as a way to gradually modify anxiety, and the nature of the objects of the inner world (Klein 1929, Hoxter 1991, Alvarez & Phillips 1998). Hoxter explains:

> *'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.' (Hoxter 1991)*

Bion explored later how the mind develops the capacity to have thoughts and think about them in a meaningful and creative way. This requires a connection between experience and emotion. The connection led to the possibility of being able to play with ideas too. For this to happen, the child needed to introject the experience of another mind able to receive the child's pre-verbal and pre-symbolic communications, feel them, process them, give them meaning and return them in a modulated way. He named this function 'containment' (Bion 1962, Hoxter 1991, Waddell 1998, Alvarez & Phillips 1998). In this context, the opportunity to play with an interested person with a particular attitude can serve as a containing experience.

Winnicott (1971) added to the understanding of play. He focused on play as a universal phenomenon that occurs in a particular 'time-space continuum'. This corresponds to an intermediate area between internal and external reality. It is a space heavily coloured with the individual's subjective experience, but also a space that can be shared with others and influenced by the external world. He explains that play and other creative activities occur in this 'transitional space'. Winnicott thinks of play, not only as a means through which children can sort out conflicts, but as a way to have different experiences and to develop. Play is not only a vehicle to express meaning, but also an activity to construe meaning and is therefore important in itself. He thinks it is vital to help a child to move from the state of not being able to play to the state of being able to do so. Winnicott explains that for play to

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occur there must be a safe space provided by an adult who would be present when the boundary between phantasy and reality became obscure and the excess of anxiety resulting from this would make the play break off.

Other psychotherapists, including Hopkins (1996), have used and developed Winnicott's ideas on play. Playing for them is therapeutic in itself because it is the child's way of thinking, developing and creating ideas and elaborating on past and present experiences that can be at different levels of consciousness. It is an activity that helps children try out and experience what has not yet been. It allows for the possibility to feel empowered and in control by re-writing their own history. Play is also important because it is a shared experience that builds up on the early mother–infant containing relationship that helps healthy separation and differentiation between reality and phantasy (Hoxter 1991, Hopkins 1996, Alvarez & Phillips 1998).

It is relevant to describe that traumatised children who are able to play tend to show certain distinctive characteristics in their play. It can turn very repetitive, stuck, intense and joyless. Through play these children bring back to life what overwhelms their mind and cannot be assimilated. The content of play and the transference might give account of the disowned memories and feelings that cannot be thought about or be mentally processed, but appear in behavior and symptoms. It can be that the content, but not the affect associated to it, is accessible or that the emotions are there but not linked to the particular memories (Hopkins 1993).

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Internal dynamics and the emotional reactions of siblings of healthy children

All children experience the birth of a sibling intensely. It normally arouses expectations, curiosity and conscious and unconscious phantasies about sexuality. It also reminds the child that he or she is not the only one in his mother's life, that his mother is a separate being and that the parents have a relationship of their own from which the child is excluded. The acceptance of a world that does not revolve around the child is potentially full of conflicts and processes that can help or impair development.

The emotional and behavioural effects of the birth of a healthy baby on the brothers or sisters has been studied by researchers and observed and discussed by parents, clinicians and psychotherapists. It is generally described as a big change for the older siblings, a challenging and potentially growing experience whose main task is the acknowledgement and integration of ambivalent and conflicting feelings (Harris 1978, Raphael-Leff 1991, Dunn & Kendrick 1992).

The sibling relationship has the potential to provide children with socialising functions that prepare them for other relationships in the external world. Siblings can offer to one another companionship and support, especially when the relationship with the mother or main carer is not sufficiently good. The sibling relationship can offer opportunities for experiencing justice, power and negotiation, interpersonal understanding and a sense of group (Harris 1978, Dunn & Kendrick 1982, Raphael-Leff 1991). It is not an easy relationship to describe in the single dimension of love and hate. There is a wide range of individual differences and emotional accents that are difficult to organise into simple patterns (Dunn & Kendrick 1992).

However, the place of feelings of rivalry and love has been, and still is, an important focus of study. Dunn and Kendrick's findings from naturalistic observations of a group of first born pre-school children, just after the birth of the baby showed that aggressive behaviour was mostly directed to the mother and that the siblings showed interest and affection for the baby. They also noticed that siblings as young as three identified easily with the baby and

could make an accurate interpretation of his wishes, needs, capabilities and emotional states. The most anxious children before the birth were also found to be those who showed least affection towards the baby. Dunn and Kendrick observed that the parents perceived more difficult behaviour between siblings than what was actually observed (Dunn and Kendrick 1992).

Levy (1937) observed children referred to a psychiatric centre and noticed that the most disturbed children were those who had a very close relationship with the mother and less age difference with the newborn.

Raphael-Leff (1991) quotes studies that describe an initial conflictive reaction of the siblings ranging from a denial of the birth itself, withdrawal, flight to a pseudo mature attitude, regressive behaviour, tearfulness, sleep and separation problems, possessiveness and rage towards the mother. Harris (1978) observed in the siblings feelings of disappointment for the arrival of a baby who is not prepared to play or notice the elder child.

From the psychoanalytic perspective, the birth of a brother or sister challenges the elder child with Oedipal issues. Freud was the first to formulate this concept. In his understanding, the Oedipal complex consisted of a universal unconscious wish in the child to couple with the parent of the opposite sex. The child had to resolve the conflict of love towards one of his parents and the hate aroused by the interfering other parent. This was a particularly anxiety producing conflict because it faced the child with being excluded from the relationship between the mother and father, punished by an angry and castrating parent, or losing the love of one of the parents. Freud (1909) illustrated the Oedipus complex with Hans, the first sibling of psychoanalysis. For Hans, the birth of his sister at the age of three made him face his parents' sexuality, his exclusion from this relationship, the rivalry with his father for his mother, castration fears, sexual theories about birth, wishes to get rid of his sister and generalised symptoms of anxiety.

Klein progressively developed a model of the mind and of the Oedipus complex that differed from Freud's model. She thought that an aspect of the mind was like an inner stage inhabited by unconscious representations that related in particular ways amongst themselves. She named this the 'inner world' and thought that the phantasies generated here paralleled our conscious activities and relationships and had a life of their own, being more or less in touch with the external reality. She thought the mind was alternating between two states with particular object relations, anxieties and defences. She named the most primitive state the 'paranoid-schizoid position' (Klein 1945). The main anxiety in this state of mind was that of the survival of the self. The mind tends to split off and project its own destructive aspects in order to survive and preserve the good object essential for mental life. The internal and external worlds are polarised into ideally good and extremely bad and persecuting objects.

With good and repeated experiences these extreme aspects are modulated and become closer to being integrated. The defences become less extreme and the awareness that the good and bad experiences are originating from the same object generate a whole set of new anxieties and relationships. This state of mind is called the 'depressive position' (Klein 1940). The anxiety here is not one of survival of the self, but the loss of the good object and the guilt of having attacked or damaged it beyond repair. It is then, when concern, guilt, tolerance of frustration and attempts to restore the object become possible. It is not easy to be in this state of mind permanently and it is common to resort to manic defence mechanisms to deal with the pain of dependence and loss. The phantasised damage, the need of the object and its separateness can be denied. The mind can resort to magical repair and an enlivening of the object as well. It can also relate to the object as if it was valueless or

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at the complete mercy of the person. The possibility of building up and keeping a balanced good object is central in Melanie Klein's theory and in her view of the development of the mind.

Klein's observations of normal and ill children placed the emergence of the Oedipus complex much earlier in the child's mental development than Freud had proposed. She thought that for young children, the Oedipal dynamics began when the 'schizoid-paranoid state' of mind, its anxieties, defences and part object relations strongly influenced the child's mental state. The challenge for the child at this stage is to manage the mental shifts that occur when he begins to realise that his mother and himself are not one and can have a separate existence.

In the very early stages of life, separation can be lived as life threatening. The existence of the father, the birth of a sibling, the existence of another relationship with the mother is strongly fought against because it faces the child with separation issues. For the child his deeply needed mother can be lost or will need to be shared. Fear and anger might dominate and the child might have phantasies that ease him for a while, such as denying the whole event, imagining he is the only one in his mother's life or breaking into an idealised place inside mother. He might also phantasise that to achieve a perfect state he must displace and kill the competitors, represented by other babies or the father. When this happens, that ideal place turns into one full of damaged, angry or dead beings. It is not safe anymore and the child must flee from it to avoid being harmed (Klein 1945).

However, if the child has enough good experiences in reality he might slowly come to trust that the mother has not been harmed, is not angry with him and that he has the capacities to help her too. This makes guilt more manageable, less persecutory and oriented towards the acceptance of loss and separation and the possibility of repair (Klein 1945).

The acceptance of the link between the parents and the existence of other babies results in the possibility of the third position described by Britton (1989). This is an important developmental step. It allows the child to be an observer of another relationship and to observe and reflect on himself. But it requires tolerating the fear of loss of the good object and the integration of the feelings of love and hate towards it. It also requires accepting that the parents' relationship with its sexual and creative nature is different than the parent–child relationship.

In general, there is agreement that the parents' unconscious Oedipal phantasies and their own sibling rivalry colours the experience of their children, facilitating or complicating the rivalrous aspect of their relationship. A healthy sibling relationship needs to be founded on the acknowledgement of the ambivalence it generates (Harris 1978, Akhtar & Kramer 1999, Volkan 1999, Balsam 1999). Therefore, the parents' capacity to accept and contain the angry and competitive feelings of the elder child and keep on loving him facilitate the integration of the contradictory and confusing feelings. The child needs assurance that there are still parental resources available for his own survival (Raphael-Leff 1991).

Shapiro (1999) discusses some factors that facilitate working through sibling rivalry and encourage adaptation and development. The mother or the main caregiver needs to be emotionally supported in order to identify with the baby's needs and to be able to tolerate the elder children's fluctuation between regression and progress. This can take the form of community support, when the father or other members of the family are not emotionally available. The parental love and protection for the baby assures the elder child in that his wishes for the baby's disappearance are not fulfilled. The parents can help the child by understanding his feelings but orienting the actual behaviour and helping him distinguish reality from phantasy. A continuing parental relationship after the birth can help balance Oedipal phantasies in the child that the belief the baby is a result of his parent and himself

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or that the other parent has actually been expelled by the child. The attachment of the baby to the older sibling can also allow the child to feel like an object of love and encourage him to respond in the same way towards the baby. Shapiro stresses the adaptive role of healthy rivalry in encouraging proximity with another person, blocking isolation, fostering co-operation, co-ordination and sharing. She also thinks rivalry encourages separation and individuation from the mother forcing children to relate to others, and to seek their own differences.

Research on internal dynamics and the emotional reactions of siblings of ill or disabled children

Research on the emotional and behavioural effects of having a chronically ill or disabled brother or sister has been divided into two main approaches. Some of these studies have a qualitative methodology using case study material, observation of group or individual processes in a clinical setting. These include projective techniques such as stem stories, drawing and play as a way to explore the preoccupations and inner world of the siblings (Hansi-Kennedy 1985, Thibodeau 1988, Bender 1990, Craft 1995, Beekman 1996).

The second approach is a quantitative one that has focused on parents or clinicians' perceptions of the siblings, using interviews or checklists that assess their levels of adjustment or maladjustment. The siblings are directly approached by the use of interviews and self-report questionnaires that assess self-concept, self-esteem, self-control, feelings of anxiety and loneliness amongst others. This approach is directed to study behavioural, cognitive and emotional aspects that are on the conscious level of the child and has focused mainly on children beginning latency and onwards (Stawsky *et al.* 1997, Fleitas 2000, Hamana *et al.* 2000).

Both of these approaches yield complementary and sometimes conflicting results and both have different reaches and limitations on how complex, deep and comparable the results are. In general, there is difficulty because the samples, concepts and methodologies used are not comparable and most of the studies cannot be replicated. There needs to be more interdisciplinary research to build a theory that could permit the definition and assessment of comparable concepts and samples.

The interview technique is limited because it can result in socially acceptable responses rather than valid responses. The parents' reports on children are also problematic because it is hard for them to be accurate when assessing the internal emotional experience of their children (Hamana *et al.* 2000). There is still not enough study on the bi-directionality of the sibling relationship, its change and evolution through time and the family unit as an inter-related whole (McKeever 1983, Bischoff *et al.* 1991). Some researchers discuss if it is realistic to expect to obtain valid data, just by using direct objective techniques, in a situation so emotionally tinted, such as having an ill or disabled brother or sister (Bischoff *et al.* 1991).

In synthesis, there is controversy whether these siblings are a population at risk or not. Mims (1997), Bischoff *et al.* (1991), Stawski *et al.* (1997) and Lobato (1987, in Lobato *et al.* 1988) found no significant differences in the areas of self esteem, behavioural and social difficulties between siblings of ill children and children in the general population. Meanwhile, McKeever (1983), Lobato *et al.* (1988), Thibodeau (1988) and Craft (1995) quote different studies that show negative psychological outcomes for the siblings of ill or handicapped children. Some of these outcomes are an increase in aggressive behaviour, anxiety, depression, poor peer relationships, cognitive and academic problems, somatic symptoms and preoccupation with their own health amongst others.

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Regarding variables, such as age, sex, order of birth, socio-economic level of the family and the type and prognosis of the child's illness, there are also no clear results. Some studies show that in bigger families the responsibility is diluted making it easier for the children. Other results point to younger girl siblings as children at risk of feeling more lonely or anxious. The older female girls are seen as having most of the care-taking burden, but are also perceived as having a role and participation that enhances their self-esteem. Girls are reported with an advantage over boys when it comes to the expression of feelings and emotions. However, they are at a disadvantage when the family dynamics are complicated because they seem to be more dependent and caught in them. Boys are reported as having more externalising responses (behavioural difficulties) to their sibling's illness and also of being more able than girls to find social support outside the family (McKeever 1983, Lobato *et al*. 1988, Hamana *et al*. 2000). All these variables might not be directly predictive of difficulties but are factors making the risk of adjustment problems or difficulties vary.

The researchers also discuss the benefits of growing up with a handicapped child. There is general agreement that this is also an opportunity for positive growth. They describe greater independence, a more responsible attitude, greater empathy and compassion for others. Gratitude for their own health, social competence, development of tolerance, greater understanding of people and insight in the siblings of ill children (Grossman 1972 in Lobato *et al*. 1988, McKeever 1983, Thibodeau 1988, Bischoff *et al*. 1991, Fleitas 2000). In general, the gains could be summarised as an enhanced awareness and sensitivity to the needs of others and to mature beyond the expected.

However, together with all the growth potential of this experience there is the risk that the siblings become pseudo mature. This means that the child rapidly represses or denies his infantile needs for the fear and guilt these needs generate in him. This kind of development can be very functional for a family with burdened parents who may feel unable to cope with more infantile needs.

The concept of 'coping' is another point to discuss when approaching the siblings of ill children. It is frequently understood as a way of dealing successfully with stress or difficulties. There can be confusion between not showing or feeling any difficulties and not having any difficulties. The brothers and sisters of ill children have many things to elaborate and integrate, but it is also true that they hardly ask questions, ask for help (McKeever 1983) or even have a conscious access to their needs (Beekman 1996).

The research that focuses on the cognitive development, style and skills of the children yields interesting results. Hamana *et al*. (2000) discuss the role of self-regulating characteristics in coping with stress. They found out that children more able to self-regulate feel less anxious and lonely when faced with the experience of having an ill or disabled sibling. For them, self-regulation consists of self-recording, evaluating and reinforcing abilities used to cope better with pain and stress. In their view, emotions are something to be controlled or mastered by cognition, not necessarily something to be integrated into the child's experience.

Thibodeau (1988) and Fleitas (2000) focus on cognitive development and access to age appropriate information to better deal with the conflictive feelings derived from this situation. They explain that young children tend to function with magical thinking, believing their thoughts and feelings can make things happen. Therefore, they can believe themselves responsible for the brother or sister's illness and feel very guilty about it. Older school age children can interpret the sibling's illness as a punishment for bad actions.

Observations made by clinicians, research based on case studies, group work and other methods have resulted in an interesting picture of the internal dynamics and anxieties that these siblings face and defences they use.

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Researchers have observed that the healthy sibling could show even more disturbance than the ill child (Cairns 1979, Spinetta 1981 in Judd 1995). Some have noticed that the siblings can identify with their ill brother or sister moved by guilt or envy, fearing becoming ill or being injured by the medical procedures as their brothers or sisters (McKeever 1983, Hansi-Kennedy 1985, Thibodeau 1988, Fleitas 2000).

Bender's (1990) report specifically deals with siblings of premature babies and their experience. She observed these children's hopes and anxieties as they showed up in dreams and drawings that expressed what they were unconsciously dealing with. One of these siblings had the urge to acknowledge the life risk situation the brother was in and that the mother could not tolerate and therefore denied. A twin boy of a dead premature brother had a strong sense of loss for his dead twin, he felt that his brother had been stolen from him and was angry with the parents who could not prevent this. He also feared the same could happen to him and that his parents would be helpless to protect him. This boy had strong feelings of isolation, loss and desertion.

Beekman (1996) observed the manifestation of the internal world of a group of latency-aged children with special need siblings, using play as a vehicle of expression. She noticed a great deal of ambivalence from the parents to allow these children to receive support. All of the children were well-adjusted and good achievers and she thought the parents maybe feared more problems would be created if the child participated in the group. She noticed that, as part of the group dynamics, the children focused rigidly on fairness and courtesy, following the rules, perfection and that their play was restrained and non-spontaneous.

The unconscious, needy infantile aspects, imperfection and unfairness seemed too threatening and were located somewhere else, many times in their group of friends. If the children acknowledged them, they could feel frustrated and angry. If they felt angry, their phantasies of damaging others could arise and be confirmed by the existence of a truly damaged brother or sister in reality. This resulted in well-behaved children with a restricted inner life. Issues such as the unfairness of having a disabled sibling, being healthy when the brother or sister was not, being healthy at the expense of the ill sibling, needing when someone else needed more, occupying space and resources when both seemed to be used up, were difficult to address. It was easier for these children not to need or depend as a way of not suffering more frustrations or disappointment. They all felt somewhat responsible and were worrying about their families and siblings constantly. They also had phantasies of how and why the disability occurred that ran parallel to the information they managed.

Themes observed in the children's play

The siblings I will discuss are five girls and five boys aged from 20 months to six years. Five of the children were the eldest child; three were the second of three children and one was third of four children. These siblings were the youngest in the family at the time the baby was born.

The play material that follows falls under four main themes:

- The temporary loss of the good object.
- Exploring a new identity in the family.
- The attempts to internalise the new baby.
- Ambivalent feelings.

All of these are themes that can be observed in many young children experiencing the birth of a new sibling. However, the intensity and quality of these seem to refer to changes experienced at a time of a family crisis.

The temporary loss of the good object – 'where is the milk. . .'?

The temporary loss of a good internal object seemed to be prevalent amongst the siblings. Some seemed anxious to find something lost, or something that was not available in the toy box, similar to a lost or unavailable object in the internal world. Sometimes the children were explicit saying that they could not find the milk or the mother in the play context. The protective figures in their play could be unstable and alternate rapidly from caring to punishing or 'cold' medical figures, showing their difficulty in these circumstances of keeping in mind a good internal object. Other siblings used the tools or medical instruments to repair the baby or the mother as a way of recovering them. Their play on feeding the parents or being identified as the feeding parents seemed to be related to phantasies of repairing the internal objects too. Some siblings showed in their behaviour by falling or dropping things, the way they might feel dropped by their internal object.

Francisco was a 20-month-old toddler, the older brother of a very ill 25-week-old premature baby girl. What first struck me was noticing that the parents expected Francisco to separate quickly from them and stay with me, a stranger, as if this was something easy and obvious for a young child to do. The other salient aspect was that the parents alternately entered and left the playroom where Francisco was and the intensive care unit where the baby was, abruptly and without previous notice. They seemed very restless and not able to focus or stay with any of their children. Similarly, it seemed very hard for Francisco to sit, explore things and stay for some time in one place, even on his parents' lap. Perhaps he found it very hard to feel he had found a right place to be accompanied, protected or entertained.

Francisco communicates his experience by scattering the toys. At the beginning he particularly picks the self-fitting containers from the toy box and drops them in the corridor. He insistently asks for a paper towel. He then tears it and scatters it in the corridors. He enters the different rooms apparently looking for his mother. He asks to be held but can just stay a few seconds in her arms. I have to come and go after him feeling what it is to be left behind with no explanation and not knowing if he will return or not.

Francisco's behaviour showed me what he experienced with his parents' comings and goings. The toy scattering and the emptying of the toy box did not seem to be expressing anger, but mainly a feeling of being dropped and falling apart. Maybe it also expressed his need to have a containing space, which was not so full of other things like babies and worries.

I shared my impressions of Francisco with his father who seemed interested in understanding more about the toy scattering. I wondered how difficult it was for his parents to integrate the idea of having a dying baby. They were in shock, moving around in an activity that seemed to keep them occupied and unfocused from what was causing their anxiety. Their understandable difficulty in staying with these emotions left Francisco exposed to bare and unprocessed anxiety.

After several attempts at talking to Francisco about his emotions, he comes to me and asks to be picked up. He embraces me and lays his head on my shoulder as if wanting to merge in a

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sleep-like state. Then he asks me to place him on the floor and focuses on a toy bus driven by a dog that pops out when a button is pressed and disappears when a lid is pushed. Francisco laughs excitedly while playing with this toy. He repeatedly makes the dog appear and disappear at his will and sometimes uses my hand as a lever to help himself have a better control over the dog appearing and disappearing.

I think that the feeling of having some control over the toy dog's presence was reassuring for this boy. It was a time when the relationship was inverted and he was not at the mercy of someone coming or leaving abruptly.

Ahmed was a 26-month-old brother of a 34-week-old baby boy who was thriving. Both parents visited the unit regularly, accompanied by Ahmed. His father seemed to be keen to stay and play with him, as if in this activity he was also identified with being a young child again. He seemed attentive to Ahmed's needs.

Ahmed begins playing representing what seems to be an ideal situation. He has his parents and me around the table and he happily pours tea for everyone. The only one who is conveniently not there is the baby. The spell is broken when the mother has to leave to feed the baby. Ahmed picks up the teapot and tries to fit a car that is too big, inside it. A while later he concentrates on emptying a tin box that held colouring pencils. Once it is empty he observes his reflection on the bottom of the box and smiles. He covers his head with the tin box and then quickly fills it up again. Ahmed checks nothing is left out and he anxiously forces the lid on again as if to be sure nothing will pop out of the box. He repeats this seriously several times as he drools heavily. At one point he throws the box away as if he was frightened of it. Father helps Ahmed move on from playing with the box to another activity. He reads him a story about a child who is put to bed by a father and comments on the daily routine both actually share. I notice that his drooling has slowed down.

The father seemed eager to understand why Ahmed could play better in our presence than alone at home and he seemed interested in the possible meaning of his play. I speculated with him that when Ahmed's mother left he wanted to be back inside her, but there was this feeling or knowledge of no longer being young or small enough to have a place.

The emptying and filling of the tin box may have been his way of showing his wish of being the only one inside his mother. He was content when he saw his reflection in the bottom of the box, probably wanting to recover that idealised space.

However, that did not last long because he also felt very anxious about having displaced the other pencils–babies from it. The box turned from an ideal container to a menacing place and he threw it away violently. He made sure everything was back as usual with all the pencils–babies inside and tightly covered, in order to avoid any angry babies from coming out and doing something bad to him.

Ahmed's heavy drooling might also have been associated with not feeling held and therefore not being able to hold his own body fluids–a physical representation of a mental state. At the end of our playtime his drooling had diminished, related perhaps to Ahmed being able to accept his father, who could offer care and interest as a holding figure.

Beatrice was the two and a half-year-old sister of a 32-week-old baby boy. The mother was careful to introduce us, waited for Beatrice to feel comfortable and explained to her where she would be feeding the baby. However, I was surprised to notice how readily Beatrice stayed with me without showing the typical signs of separation anxiety. It seemed she managed separation by simply denying its existence.

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In her relationship with me, Beatrice needed to direct and be in charge. She would take my hand and guide me around the corridors. She stayed physically very close by sitting on my lap, asked me to hold her or sat by my side, leaning on my arm as if she needed close bodily contact to feel calm. She also left her mark on toys by licking them and marked my hands, the floor and a nurse's trousers with the pens. I wondered with her if she did this to help us remember her.

Beatrice asks me to sit by her and pour tea, 'more and more tea'. She insists that we should play this game using water. She lets me know how hungry she is and that what I am serving is milk, not really tea. I comment that she feels she needs a lot and might be worried that Luke will not leave any of Mummy's milk for her or any Mummy at all.
...Later she takes me to the room where her mother is tube-feeding Luke. After watching her and asking about the tube she takes me back to the play room and steps into the toy box, looking at me in a challenging manner and sits inside the box. I comment on her need to have a Mummy all to herself to hold and cuddle her. Beatrice nods and steps out... She picks up the toy phone and pretends to be informing her mother she is busy playing with me. Then she continues talking in German, making me feel confused and left out. I show this to her but our voices overlap. I tell her she might feel she can't really get through to me and that I can't really understand her. Beatrice then places her mouth on a piece of paper, sticks a chewing gum on it and un-sticks it. She repeats this until the moist paper breaks. I comment she needs to be very close together almost stuck to Mummy and that she might feel full of holes when Mummy is not around.

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Perhaps Beatrice's need for a concrete physical contact with another and her relationship with surfaces was a way to communicate a profound fear of becoming invisible or being lost, activated with the birth of her brother. This might have been particularly difficult when she was concretely faced with the reality of a busy mother feeding her brother. I understand this as a momentary state because Beatrice was also capable of symbolic play, which will be discussed later. However, there was a risk that her mature appearance left her more vulnerable aspects unseen.

Sarah was the three and a half-year-old sibling of a 34-week-old baby girl. She had been premature herself and had required repeated medical treatment during her first year of life.

On our first encounter, Sarah looks in the toy box for the family. She finds the baby, the sister and the father but she can't find the mother... Then she picks up the self-fitting containers and places them upside down and uses them as beds. These are hard beds, a supporting surface but not an enclosing one. Sarah lays the baby and the girl on each bed. She makes things softer by looking for a piece of cotton that she uses as a pillow. She can't find the bottle of milk but picks up a white crayon and tells me: 'We'll pretend it is milk'. She finally decides the toy nurse will be Mummy and makes her push the girl out of her bed, then makes the mother place the girl back on the bed and hit the father.During the game the toy representing the father suffered several changes too. He alternated between being caring or aggressive. He was either a 'true' father or a 'fake' one and also could be a 'father–doctor' figure. Sarah was alternately identified with a good or naughty sister or the baby.
On another occasion Sarah used the inside of the teapot as a space for the members of the family. However this place also turned bad as it got crowded and the family members were forced in it as a punishment.

In Sarah's play the baby doll and the sister doll both experienced being at the mercy of parental figures who appeared unstable. They could be caring or damaging. They could be

caring in a cold medical way or in a more affectionate father- or mother-like way. Their roles and characteristics were confusing, difficult to follow, predict and trust. It seemed that a good stable internal object could not be secured. Some of the toys, like the cups and the teapot, she used as shelter for the toys, which may have represented a containing function, had the same changing quality. They began as a protective space that was spoiled by turning into an overcrowded punishing place. The alliances between parents were also unstable, sometimes supporting each other, and sometimes acting as enemies. At times the parent–child alliance was protective but later turned into an accusing one.

Carl was a three and a half-year-old boy who came to the unit with his father. His mother was still hospitalised. Carl's father commented that she seemed depressed. Carl gave me a first impression of a shy, fragile and serious boy who needed time and some help to begin to explore the toys and play.

Carl's first communication is to hold up the tiger puppet and make him ask: 'Where is the milk?' He searches in the toy box but can't find it. I feel he is so anxious that I can't contain myself and offer this tiger a cup asking if he could use the cup to have his milk. The mood is alleviated and Carl giggles making the Tiger delightedly swallow his milk... Later in his play he comments that 'mother is not here'. Carl begins playing at being a doctor but later identifies himself as a patient, a little boy who also, as his baby brother does, needs milk and medical checking.

Carl might have been conveying how needy he was of a nourishing mother presence, particularly when his mother was actually not available. The pretend milk seemed to represent some aspects of the good object. It was interesting to note that the father seemed to be present as a caring and attuned adult and that Carl was able to make use of his presence. He easily engaged with his father, livened up and was able to ask him questions about his mother and the baby, locating a good object in him.

Fatima was a four-year-old girl with a very ill premature brother who had little chances of surviving. Fatima looked unkempt and abandoned when visiting with her mother who in turn seemed shocked, emotionally frozen and lost in the unit. The first time I met Fatima she was wandering by herself around the corridors. I found myself engaging with a little girl who seemed motherless. She could hardly talk, but when she did she was capable of clearly expressing what she wanted.

The first part of her play consists of meticulously pairing things in couples or completing them. She names each object as she picks them up and sorts them out. I show her how she is pairing things that go together like a mother and a baby, a girl and a mother, a mother and a father... She then makes her play revolve around her real mother. She takes the role of feeding her by taking her some tea, fixing her by offering her two sticks that look like supporting crutches 'to do exercise' and tries to enliven the mother by showing her some toys and games. The mother sits by the empty baby's cot (the baby is having a medical exam somewhere else). She doesn't seem to respond or react to Fatima's efforts. She looks frozen as if in a state of pain. Every time Fatima comes from the room where her mother is she brings back the toys and pretends to wash them as if to clean them of something bad located in that place. When I comment about this the play is broken. It seems that the dread of malformation and possible death is something that is too terrifying to be named and addressed.

It seemed as if Fatima was desperately trying to bring back to life her seemingly damaged and lost mother. This was more touching by the fact that it was not something only occurring in Fatima's internal world but also in the real one. At times she identified with the

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caring abilities of a maternal object by caring, feeding, entertaining and trying to cure her mother. Fatima had turned herself into a 'mother's repairer' and was very attentive to her emotional state.

Exploring a new identity in the family – 'I will be the...'

The birth of a brother or sister challenges the child with the need to reconstruct his or her own identity. The siblings I observed were all youngest in the families at the time the baby arrived. Their task was gradually to stop being the baby and start being an older brother or sister. This meant dealing with a sense of loss, but also gaining autonomy and new capacities. The play situation allowed them to explore different identifications, phantasies and the emotions linked to them. The children played at being the mother, the baby, the nurse or doctor and gave me similar roles. Being another person in the safe place of a play situation might have permitted these siblings to become aware of some unknown capacities to take care of others and soothe themselves.

The medical staff on the unit impacted upon the siblings. At times the children identified with them in their play. While being the 'doctor' or the 'nurse', the siblings could do painful and 'necessary' things to the baby in their play without having to be responsible. By doing this, the children were able to take a distant emotional position from the actual baby, a safer position to be in when negative feelings were aroused and when the curiosity to discover what and who this baby was, emerged.

Wanda a six-year-old girl readily took the role of a nurse that cut the elephant's trunk. This nurse was cold and distant in relation to the baby. She expected the elephant patient to allow himself to be pricked and cut without explanations or without complaining.

Carl also identified with a medical figure. He coldly 'operated' on the baby lion and cut his mane.

Beatrice asked for my identification tag actually to 'be a nurse'. As a nurse she had to operate on the baby and cure him too. She used a lot of time and dedication to clean and heal the baby's wounds. She was able to identify with an emotionally involved nurse aware of the baby's need to be soothed.

The children explored being just a child:

Children like Beatrice and Carl also explored the possibility of being a very hungry child that needs big amounts of milk or a little boy who also needs checking and feeding. For them the position of the older sibling conveyed a sense of urgency in having their emotional needs met.

Many children identified with the mother's role:

Beatrice was a mother of four babies. She explored her caring and soothing capacities in the mother's role as well as more destructive capacities when in the nurse's role. This allowed her to play with certain emotions which she didn't allow herself when identified as the older sister of a baby brother.

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Ella used me to get rid of an undesirable older sister position and secured herself in the role of the mother. In the mother's role she was able to become closer to the baby but very distant to the child as if both relationships were very difficult to consider at the same time.

The attempts to internalise the new baby – 'A premature baby in the mind. . .'

It was interesting to observe the way in which the premature baby lived in the sibling's mind. This seemed to be influenced by the way the baby was internalised and how reality and phantasy were transformed in the process. Projective processes that originated in the child, the institution and the parents all seemed to play a part in the way the premature baby was internalised. This baby seemed particularly hard to represent. At times I had the impression it lived in the children's minds as a hard, mechanical or malformed being. In many cases it turned out to be a dangerous and persecuting life form transformed by the siblings' own projected aggression. This alternated with an ideal fragile and sweet baby that needed caring and fixing. It was hard for the young siblings to have a clear idea of how many babies there were, whom they belonged to and what relationship they had with them.

Ahmed began our play sessions by making sure the 'beast' was placed far away. The beast was always the lion or tiger puppet and Ahmed shivered and retreated in its presence. Ahmed's play was centred in getting into closed spaces, emptying and filling boxes of their contents and trying to fit into them.

Duncan (27-months-old) presented as a restless little boy. He had a difficult reality to bear as a sibling. His mother was pregnant with twin girls and one had died before birth. It was not known if the surviving twin baby was at risk too. Duncan was anxious about the idea of meeting his surviving baby sister.

Duncan tried to fit two identical buggies in the back part of the truck saying 'these are babies'. He clearly told his mother that he had come to play but that he didn't want to see the baby and go 'in there' (the low dependency room). He seemed very frightened of what he could find in that room. At the same time Duncan felt impelled to go into the room protected by his empty pushchair that was meant to carry the baby. However, he couldn't actually go inside. Duncan ran back into the corridor laughing in a tense manner. He began to run in circles looking back as if something was chasing him and then he fell. He repeated this several times until he was exhausted from running and his mother had to come and calm him.

Duncan's understanding of two babies inside mother was one of the first things he communicated. Then the play became disorganised and he became much more active and anxious. Duncan seemed very frightened by something invisible and shapeless. I wondered if this was linked to his fear about a dead baby as well as the emotional impact of this experience on his mother. This fear was difficult to define and therefore to process. Perhaps Duncan not only had phantasies about himself in relation to the dead baby but also about how dangerous the live baby and his mother might be, having in phantasy colluded in the death of the other twin.

Carl showed confusing images of the baby.

At times he was Doctor Carl tube feeding or coldly operating on the lion puppet. 'This is like my brother', he would comment. 'My brother is in an incubator', he would add. At one point in his play the monkey puppet, which played the role of a Doctor, fetched the baby to operate on it. I was surprised when Carl chose a plastic rectangular music toy to be the baby.

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In Carl's mind, the baby was an alternating being. One of them was more clearly defined and closer to a human that needed feeding. Carl was probably trying to sort out what kind of baby would have a tube to be fed instead of having a mother. What kind of baby too could have left him with an ill mother? Maybe it was also hard to distinguish where the baby began and the life support machines ended. It seemed that the alive, soft and human-like baby and the inert, hard-mechanical baby co-existed in his mind.

Jeremy was an expressive and engaging child.

Jeremy began playing with a small plastic toy boy placed in a cup and he called it 'the baby'. He repeatedly played at making the baby disappear into a traffic cone tube, placed in the corridor, and making the baby appear by lifting the cone. He would stop the doctors and staff to show them 'Look, 1, 2, 3, baby gone!' Jeremy would delightedly drop the baby in the traffic cone and ask me to run with him to the other end of the corridor and watch if the baby would come after us. The pleasure of this game was gradually lost and his excitement turned into acute anxiety: 'Run, run,' he would say pulling my hand. 'Baby angry... baby gone!' 'Baby pinch... fork... run.' He would frantically run away from this almost hallucinated angry and pinching baby that chased him.

It was interesting to observe how the baby was gradually transformed as the play evolved and as Jeremy's aggressive phantasies affected it. It began as a contained baby held by his mother–cup and was then displaced from his mother–cup and dropped into a cone. The baby could be recovered and the tone of the game was festive. However, this gradually changed and Jeremy introjected the hidden baby as an angry baby. Then it seemed to have been projected again as something close to a hallucination and difficult to describe. This 'something' was angry, persecuting and pinching. As in Carl's and Duncan's case, the internal baby gradually lost his more defined or human qualities and turned into something shapeless and distant from a human baby, giving us a view of the baby that resided inside their minds.

Beatrice chose several puppets as the babies' representatives. She dealt with them one at a time either feeding the babies, making them go to sleep, cutting them or firmly scolding and shaking them. However, at one point, after visiting her real baby brother in the other room, she picked up a rattle of four plastic bears joined by a string and declared 'these are all my babies'. Then she brought them to the room we used to play in and sat them on the toy chair. She told me she wanted to make food for her babies.

Beatrice only had one baby brother but in her games several babies were present to be fed, cured, cut, shaken or scolded. It may have been difficult for her to distinguish how many babies her mother really gave birth to. For many of these young siblings visiting the neonatal unit might have confirmed phantasies of multiple babies because the unit was full of babies too.

Ella complained about her baby, 'this baby is just sleeping... sleeping for 86 weeks.' We talked about the long hours she spent waiting for the baby to wake up. This baby barely noticed her, didn't look at her and seemed indifferent. She agreed the baby was difficult to see because there were things around her in the incubator. Ella played with the puppets that represented her babies and other babies. She couldn't decide where to place these other babies. She didn't know whom they belonged to and finally left them under the chair.

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The baby seemed to be experienced in a similar way as the internal mother, not noticing, not waking up, absorbed in her own world. The baby was unreachable and impenetrable for Ella. She seemed more frustrated and rejected than persecuted by the baby. This baby was represented in a more defined and human way. It might be that Ella, being an older girl, was operating with more repression making the primitive phantasies about the baby more difficult to reach.

Ambivalent feelings–managing love and hate

Although ambivalence is a common feature of all object relations, the amplitude of the ambivalent feelings seemed more extreme. These children had particular difficulties managing their angry feelings that led to some of the persecuting images of the baby, the parents or the containing space described before. Some siblings showed acute anxiety with certain toys or tools that might have represented the possibility of doing harm to or being harmed by the baby. At times, when the limits between play and reality seemed to be lost, the children broke off their play to check if the baby and the mother were still alive next door. Many showed great anxiety and intolerance of the crying babies as if the crying was an accusing evidence of a phantasied damage done to them. They also feared the baby might wake up and get back at them and felt relieved when they checked and noticed the baby was still sleeping. Some siblings showed how the anxiety generated by their own angry feelings could interfere with their motor co-ordination and their ability to concentrate and focus on their play, making them appear clumsy or hyperactive.

> *Ahmed has an ambivalent relationship with the tin box. At one point it is a desirable place to be in and a few minutes later it must be thrown away because it seems dangerous.*

It is possible that what changed the nature of this object was the phantasy of intruding in it and getting rid of all the rest of the occupiers. The aggression implied in this might have left, in the boy's phantasy life, a damaged and a non-secure place full of vengeful creatures.

> *Jeremy has just left the low dependency room where his Mother is feeding the baby. He is in the playroom with his grandfather and seriously warns the grandfather the food is burning hot, a few moments later he asks me for sugar to add to the food...*

Jeremy was feeding his grandfather with something hot, perhaps like his hot angry feelings at seeing his mother busy feeding the baby. He then seems to want to make this better and good by adding something sweet.

> *Later in his play he takes the baby doll from its contained place, a cup, and drops it down a tube making it disappear. The contents of the play turn progressively more threatening, the baby is angry and after him, there is something prickly chasing him... he asks me to draw an aeroplane with eyes and nervously drops it asking me to erase the eyes... He seems very frightened of them.*

The play progressively communicated Jeremy's persecutory phantasies. The baby wanted to capture him and maybe prick or burn him. The baby now became the one who carried his own angry and pricking feelings. The aeroplane's eyes represented part of Jeremy's strict super ego functions that accused him for his actions, making persecutory guilt emerge. These accusing and checking eyes had to be eliminated because they were very hard to tolerate.

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Beatrice is troubled by her own aggression:

She repeatedly asks me to read her a 'favourite' book. It's about a cat that is very hungry and does naughty things like eating the pet fish and the family's lunch, tearing the sofa's cover and making a mess of the wardrobe. The cat is finally sick with all he has eaten. Beatrice is absorbed by this story and insists the cat is not naughty.

For Beatrice the cat story provided momentary relief. It was the cat and not her who was greedy and destructive. The cat could carry her unacceptable feelings. When these aspects were taken in, she identified with them again and she seemed wary that the cat was evaluated negatively. The closer her needy aspects came to her consciousness, the more troubled she was with the guilt arising from the damage caused. It is interesting to observe that the story represented a possible internal dynamic. The cat introjected or ate something full of projected hatred and then he was affected by it, he felt sick and had to expel it or project it again.

Later Beatrice insists I use the thermometer to prick the baby. She refuses to do it herself but seems fascinated watching me giving the baby tiger an injection.

I thought it was easier for Beatrice to bear her destructive impulses if it seemed they did not belong to her.

The play continues and she decides to nurse the tiger. She is very sweet, tender and caring with him. She cuddles and soothes the tiger. Following this she pricks him and then gives the tiger 'Calpol' to make him feel better.

Beatrice shows how she can alternate between loving and hating feelings, she also shows some reparative tendencies.

At one point she goes back to the tiger and shakes him angrily as she exclaims: 'Stop crying!'… 'Be quiet!' She then throws the tiger to the corner of the room. Beatrice stops playing and asks me to follow her to the room where her baby brother is.

The crying tiger reminded Beatrice of a harmed and accusing baby. This might have been too hard to bear; the harm had to be denied and the baby's cry must be stopped. Maybe the play broke down because she could not tolerate the anxiety produced by the guilt of having damaged the internal baby.

We are next door where the mother is tube feeding the baby. Beatrice touches the baby's head commenting that he is sleeping and touches the tube saying it is for 'Calpol'. Another baby begins to cry and Beatrice looks worried. She goes to check him and tells the nurse she wants to feed and cuddle this baby.

Beatrice's attitude toward her baby brother and her worries and intention of soothing the toy baby showed perhaps that the play with the tiger stood closely for her ambivalent relationship with her own baby brother. In the external world, Beatrice allowed mostly her tender feelings to appear, but it is in the play situation that the full emotional impact of the birth emerged.

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Carl includes plenty of cutting things in his play. At one point he is being Doctor Carl who feeds the lion and then begins coldly to cut its mane and take blood from him. He has to stop the game to go to the toilet. Then he goes to the low dependency room where his father is holding the baby. He jumps anxiously around and gently pats the baby's head commenting that the baby is sleeping. He seems relieved by this.

I think Carl could not hold himself any longer and needed literally to evacuate the anxiety generated by his phantasied aggression represented by the cutting. The play was broken and he had go to the toilet and then concretely make sure the baby was still there, hopefully sleeping as a quiet and peaceful baby, not a damaged and angry one.

Sarah is caught up with her ambivalent tendencies. Her internal objects unpredictably change from caring to aggressive. The safe spaces do too.

Sarah makes the doll rest and sleep. Then father doll comes and checks if she is all right but suddenly the checking turns into a cold medical inspection of her stomach and legs. Something similar happens with the mother doll and the little girl doll. The mother takes care of her but shortly after scolds her for being naughty and pushes the girl out of the bed...

Sarah places the father doll in the back part of a truck and tells me 'daddy is going to the office to work'. Just a minute later she says 'dad is in jail (in the back part of the truck) for being naughty'.

The recurrent theme of naughtiness and sudden punishment in Sarah's play might have been an expression of her difficulty in dealing with the aggressive feelings that are part of relationships. In her case, her personal experience of being a premature baby and a frequently hospitalised toddler might be added factors to the experience of having a premature sister. It might have been difficult for Sarah to integrate the experience that the people who cared for her were the same people who caused her pain. Sarah had at the time of my observations, a confusing and non-trustworthy internal scenario. This might explain part of the unpredictability of her internal objects.

Ella gives me a first impression of a girl with co-ordination difficulties. She constantly drops the pencils, the chair, spreads the papers or crumples them. She seems clumsy and a bit harsh when handling the toys. She insists on looking for the scissors, she says she 'wants to cut'. As the session progresses and she gets the opportunity to cut, her movements become gentler and better co-ordinated. I am surprised at one point to notice how tender and gentle she is when she picks up the tiger and cuddles it like a baby. I am also surprised at her harshness when opening her sister's incubator and the gentleness she shows when actually handling her.

Ella seemed to repress her aggressive tendencies at the cost of good co-ordination. It seemed as if her motor system was giving her two opposing orders, leaving her disorganised and uncoordinated. I thought I was observing the bodily and behavioural effects of dealing with ambivalence. There seemed almost to be a split between the gentle, co-ordinated Ella in relation to the baby and the harsh uncoordinated Ella in relation to other objects. Ella needed to do something with her 'cutting' feelings; play gave her a safe place in which to express them.

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On a second meeting Ella begins by sorting out the tools and the medical instruments. She throws away all the ones with sharp edges and keeps the rounded ones. She also selects the orang-utan puppet from the rest of the puppets and throws it away.

Ella seemed to be trying to rid herself of her conflicting feelings. All the tools that were harmful were eliminated from the game. The orang-utan puppet, the one that most resembled a human baby, was left out too.

Discussion

In this paper I explored, through the eyes of their young siblings, the experience resulting from the birth of a premature baby. I observed in these children aspects of the feelings, preoccupations and issues that they were dealing with through play.

The siblings' particular experience was influenced by factors specific to the family situation. They had to deal with the presence of preoccupied and less available parents, some of them suffering from symptoms similar to 'post traumatic stress disorder'. These parents could be emotionally very needy and not in a position to contain the children's own needs. The siblings had to deal with the reality of a baby whose health was at risk or damaged beyond their ability of repair. They were also exposed to the dynamics of an institution in which anxieties, conflicts and defences were prevalent.

The temporary loss of good objects (internal parents), the diminished institutional and parental containment and the absence of external reality to modify and disconfirm phantasies of damage were, for the siblings, potential traumatic experiences in themselves. These experiences might have made it harder for these children to sort out the conflicts arising from their own ambivalent tendencies. It might also have influenced the way in which the baby was internalised and represented.

I have the impression that in the group of siblings I observed, the phantasies, defences and anxieties were predominantly from what Melanie Klein describes as the 'paranoid-schizoid position' rather than those associated with the 'depressive position'. There seemed to be a prevalence of persecutory guilt, denial of damage and manic reparative attempts in the children's inner worlds. There seemed to be more splitting and projection than integrative processes. The siblings showed in their phantasies more part object relations marked by the difficulty of integrating good and bad aspects of the same object than whole object ones. These children's developmental stage might have facilitated the expression of these dynamics that become harder to visualise during latency.

I am aware that in this paper I have chosen to focus on the children's play leaving out issues such as race, culture, particular family dynamics and historical and constitutional aspects of the child, all of which probably shaped the way in which these siblings internalised what they were experiencing. It is important to remember that the observations carried out in the particular setting of a neonatal unit cannot necessarily be extended to other settings, like the home and school, because the unit had particular dynamics and it triggered anxieties of its own. Nevertheless, this intentional focus was an initial step to highlight and make more visible their experience in a time of crisis. I hope some of these initial observations might help mental health professionals to design similar programs that support the brothers and sisters of babies and ill children.

When I approached the parents to explain the service that the project provided I received different responses. Some readily let me know that their child was all right–'delighted' about having a baby. Others felt split and worried about the well-being of their other children. Some parents refrained from telling their children about the pregnancy or the

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birth and had a strong desire to keep the children's world unchanged for them. Other parents were at times in touch with their children's difficulties, but had rapidly to dismiss the worries and make their elder children appear better to them. It seemed as if the parents needed to have at least one child who was doing well.

When I first began this work, it seemed as if it could easily be seen as something unimportant. It felt as if the 'real thing' was happening between mothers and babies in the actual ward. Therefore, I was impressed when I observed how readily the siblings engaged in play and used the presence of an interested adult to express and sometimes sort out their phantasies, anxieties and feelings about the changes in their family life with the birth of a fragile or ill brother or sister.

The nature and setting of the sibling project shaped the frequency and predictability of my relationship with the siblings. Many of the siblings visited the unit at irregular intervals and unpredictable times. A few were regular visitors. I had therefore brief views of their 'internal worlds' and tried to make the best possible experience for the children out of these encounters. The interrupted characteristics of my relationship with some of the siblings probably mirrored their presence in the parents' mind at the time of a family crisis. My relationship to the siblings was interspersed with periods of absence. In those periods, I kept contact with them through their parents and I tried to keep the children present in their parents' mind. I understood my role as a mediator who gave voice and presence to some of the siblings' possible experiences and needs.

As I have mentioned, one of the characteristics of this kind of work was the unpredictability in the number of families and children present in the unit. Busy periods alternated with spans of time where there was nothing visible to do. It was then I reluctantly had to face what most family members experience. I felt the long wait, the tedium and the invisibility of my role. At times I thought I was completely de-skilled and with no relevant knowledge.

The opportunity to receive supervision helped me to understand the feelings I have mentioned and to recover the meaning of my role. I learned not only to accept these difficult feelings, but they became central in understanding some of the unconscious dynamics in this particular context of work. The support I received allowed me to be in contact with that part of the experience that was necessary to keep in touch with the siblings and their families.

I want to discuss briefly my impression of the fathers' role in relation to the siblings. The fathers I observed had an important role in supporting these children. Some helped to provide continuity in the maternal functions while the mother recovered. Other fathers identified with their child and allowed themselves to regress momentarily. This facilitated the fathers' involvement in play and their understanding of their older child's feelings. Some fathers took this experience as a chance to be in contact with their sons and daughters and recover a time for play and companionship and in the process they helped their children to separate from their mothers. There were also fathers who could not find a place in the very feminine space of the neonatal unit and they rarely visited. Finally, other fathers seemed to be as frustrated and angry at the birth of the baby as their young child. It would be interesting to explore this area further, considering that the fathers are usually the other forgotten members of the family at the time of the baby's birth.

Participating in the sibling project gave me many rewarding experiences. Some parents in particular brought their children to 'play' with me. Many fathers showed interest in the meaning of their children's play. My availability for the siblings and my interest in their play and behaviour helped to raise a general awareness in the parents and the staff of the neonatal unit of the other children in the family and their emotional needs.

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