A PSYCHODYNAMIC INVESTIGATION OF A PREMATURE BABY
UNIT: THE IMPLEMENTATION OF AN ACTION RESEARCH
STRATEGY.

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ABSTRACT

The thesis explores a malfunctioning Intensive Care premature baby Unit. An action research strategy is followed in order both to enhance understanding of infant, parent and staff experiences and to facilitate change. The project explores 3 groups: staff, parents and the premature babies, their interaction and impact on each other.

The hypothesis of the dynamic and systemic source of the difficulties present on the Unit was reached after interviewing groups of staff, nursing students and some informal observations of interaction between staff and parents and staff and their patients.

A picture of a part-object culture in which human concerns and feelings were reduced to a very low state was revealed, mechanical discharge of duty was observed.

The second stage of the project deals with creating the tools to facilitate some work to change the culture on the unit.

The nature of the emotional difficulties and the defensive strategy of the staff is explored in a staff group where the task is exploring these difficulties, identifying them and working to bring about some understanding and change.

The impact of premature birth on parents is studied via individual cases and the parents' support group. Evidence for the traumatisation of the "adult" personality of the parent emerged from these sources. Primitive anxieties and defences take centre stage in "the premature parents". Some intervention with exploration, understanding and support is offered in the Parents Group, started by this project.

The premature infant's object relation is considered in the last chapter of this work. His early life experience
is very different from that of the full-term baby. Some of the psycho-analytical theories on mother-infant relationship are reconsidered in the light of observations conducted on the Unit. It is clear that some further work is needed. One model is proposed. Some observations are discussed and further work in this field is planned.
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# TABLE OF CONTENTS

ABSTRACT ................................................... 2

ACKNOWLEDGEMENTS ........................................... 4

CHAPTER 1. THE TASK, AND A REVIEW OF THE LITERATURE ................................................. 7

  1.0 Description of the task ............................... 7
  1.1 Psychoanalytic discoveries .......................... 15
  1.2 Early anxieties and defences ........................ 15
  1.3 Organizations as a defence against anxiety ... 37
  1.4 Action research ........................................ 44
  1.5 Psychological investigations in the neo-natal field ............................................ 64

CHAPTER 2. METHODOLOGY, THE PRACTICE ...................... 82

  2.1 The first phase, assessment ............................ 82
  2.2 The second phase, intervention ......................... 92
  2.3 The third phase, the work of the staff and parents groups .................................. 102

CHAPTER 3. THE PROCESS OF ASSESSMENT OF THE CRISIS ON THE UNIT ..................................................... 109

  3.1 Introduction ................................... 109
  3.2 A planned meeting with staff, dealing with negative data ................................. 113
  3.3 A meeting with student nurses ..................... 116
  3.4 First informal visit ............................. 122
  3.5 Second informal visit ............................ 127
  3.6 The essence of the problem ..................... 135

CHAPTER 4. THE WORK OF THE STAFF GROUP ................... 137

  4.1 Starting a staff group .............................. 137
  4.2 First clinical example, the use of idealisation and denial .................................. 143
  4.3 Second clinical example, the use of "implicit interpretation" ............................. 154
  4.4 Third clinical example, change in the defence system of the group ..................... 162
  4.5 Fourth clinical example, reversing an identification and making it available for thought ........................................ 169
  4.6 Discussion .............................................. 178
Chapter 1. The Task and Review of the Literature

1.0 Description of the Task.

This thesis describes a project of psycho-analytic action research in a malfunctioning Neo-natal Unit. The work may be considered as having three phases: firstly a diagnosis, secondly the building of a setting for work, and thirdly working with the staff and the parents of the premature babies. There was considerable overlapping of these phases in the actual work.

A letter from the Director of Midwifery Services to the Psychiatric Division requesting help for the Neo-natal Unit of the hospital started this project. The Director wanted help for one particular member of her staff as well as for the nursing staff of the Unit as a whole.

From her letter and a subsequent meeting we had, I understood that she felt that things had been going wrong for some time. There were worrying events on the Unit: equipment was damaged, perhaps deliberately; instructions were ignored; the atmosphere was cold. The Director put it in the following way: "People are always running with their aprons flapping". She worried as to how long it would be before patients' care would be affected. She told me that she spent a great deal of her time in the Unit talking to the staff. She sent people on courses, some were allowed extra time off, but she did not feel
things had improved and that was when she called for outside help.

There was some anxiety about what was going on on the Unit. The staff conveyed a sense of wishing to flee, not coping, being overstressed, one member of staff was seen as mad, attacking the equipment.

It was possible that the staff were fleeing from the "boss" Miss D, who was no longer one of the nurses on the shop floor. It was possible that her shyness might have been taken as remote superiority: I was not convinced by this possibility.

Miss D was clearly worried about possible damage to the babies. In other words she was afraid that a baby would die as a result of neglect or attack. She was seeking help from outside for this nurse who later was moved but there was also a sense that the malaise was more wide spread.

I wondered if the single nurse was an ill, disturbed person or was displaying her own, as well as the pathology of the Unit. I was not actually asked to see the individual nurse nor was I thinking at the time that some sessions with me would solve the problem of the Unit. The Director's concern was grave. I made it clear that while I would like to help I could not guarantee the safety of the Unit. This was accepted and it was agreed that I would meet the Nursing Officer, the qualified staff and then the students nurses in separate meetings and then come back to discuss my findings with the Director and her deputy.

I thought after my meeting that a sense of despair that the work with damaged, ill babies generates, might have
brought "an acting out" by one member of staff, who acted what was felt on the Unit, namely: it was a place of damaged, un-functioning babies. Another worrying thought was that the external ill babies got confused with damaged internal objects. The need to externalise and concretise in order to get rid of this as well as the parents' projections of their sense of their failure was at the core of the difficulties I had just heard about.

The task at the beginning of the project was to try and change all this. A process of exploration in the diagnostic phase exposed "a part object culture" in the Unit, strong paranoid feelings, depressions and isolation. There was no sense of a helping or containing presence. Individual nurses were caring human beings, but the dominant feature in the atmosphere on the Unit was that one pair of hands was the same as another. People and their concerns and feelings were of no importance.

As the work progressed some development took place and the task of the project was expanded to try and help staff in their work not only with the babies but also with the families of the babies on the Unit.

The Neo-natal Unit

Approaching, you see a two storey building in the hospital grounds containing the Maternity and Gynaecological Wards. Some of the usual scenes outside are a car with excited relatives, a man with a child, someone delivering flowers, a nurse handing a well wrapped-up baby into a car.

Located on the first floor through a double door is the Neo-natal Unit. You open the door and you enter another
world. Instead of the air of excitement surrounding the birth of a new baby in a Maternity ward, there is an atmosphere reflecting the intense worries about the well being or the survival of the baby here. Off a wide corridor decorated with pictures, plants and wall murals, are a mothers' room for the mothers who have given birth and whose babies are in the Unit, staff sitting rooms, a kitchen, offices, bathrooms etc.

Through a further door is the nub of the Intensive Care Unit. You see rooms for very ill premature babies with lots of equipment surrounding the incubators, rooms for Special Care, with less electronic equipment, a nurses station, mothers' rooms, doctors' rooms and kitchens for staff and parents. It is a brightly painted place looking usually very busy. In here it is another world, where babies are usually very tiny or ill, or both tiny and ill, with a great deal of electronics, and anxious families.

The Neo-natal Unit is a Sub-regional Unit. It looks after 300 babies a year. It is a twenty cot unit, four to five are Intensive Care cots and the rest are Special Care cots.

The babies are mainly from the local Health Authority but one or two Intensive Care cots are available to the national computer that allocates Intensive Care cots. The survival rate of the babies is comparable to the national rate.

The staff

Miss D, who asked for help for the Unit was the Director of Midwifery Services of the Health Authority and had
been very involved in starting the Unit. She was in her late fifties and struck me as dedicated, somewhat reserved, of the "old school" tradition in nursing. She had been in nursing all her adult life and had received an OBE for her services. I felt that she was serious, sensitive, and a bit aloof.

There are 30 nursing staff positions (actually 25 nurses in post). Most of them are midwives who have done the 405 course for Neo-natal nurses. There are a number of nationalities among the nurses: Chinese, and Irish are the majority. Their work is looking after the babies, feeding, giving drugs, intubating, taking blood, cleaning, monitoring and recording. The nurses also assist the doctors in some of the medical procedures. If they are in the Intensive Care rooms they will spend their time looking after two or three babies who are "wired" to a number of machines and monitors. These produce warning sounds almost all the time. There are some very anxious moments when the nurses have to look after both the babies and the very upset and anxious parents. As in all Intensive Care Units there are times when there is a crisis and nurses are under intense pressure, and there are quiet times and not enough to do.

The doctors are Paediatricians. There is a Neo-natal Consultant, a Senior Registrar and a Registrar on the Unit. House officers also work on the Unit and in outpatient paediatric wards of the Authority. The junior doctors rotate every 6 months. They too are from many different nationalities. Some are hoping to become paediatricians, some are on a GP training course.
Terminology

Premature babies are those born before 37 weeks gestation. Low birth weight infants are those who are born having a weight of less than 2500g (LBW). These infants are either born too soon (preterm) or too small for their gestational age. 18–40% of low birth weight infants are small for their gestational age (Brothwood et al 1988).

LBW infants make up about 7% of all annual live births in the UK and the USA (Alberman, the Lancet 1980, 1 p189-190). About 10–15% of LBW infants have a very low birth weight (VLBW) i.e. less than 1500g and comprise 0.9% of all live births in the UK. The care of VLBW infants comprises the major work load in modern Neonatal Intensive Care Units (Behrman, R. 1985). The survival of LBW and VLBW infants has improved over the last 15 years whilst the prevalence of handicap has remained stable and relatively low at 6–8% of total VLBW (Stewart et al 1981). A more detailed finding is produced by Bauchner and Pharoah and others who state "Although recent study reports vary in regard to birth weight bands and are mainly based on studies in well equipped regional centres, their findings are consistent in showing that survival is generally less than 25% for infants between 500g and 700g (Bauchner et al 1988), around 50% for infants of 751-1000g, around 90% for infants weighing 1001-1500g and more than 95% for infants weighing 1500-2499g at birth (Pharoah and Alberman 1990). Increasing survival rates mean that Paediatricians are now caring for more pre-term infants and who on average require longer periods of hospitalisation and more resources than ever before (Bloom, 1984).
The patients of a Neo-natal Unit

6- 8% of live births need admission to a Neo-natal Unit. A Neo-natal Unit cares for the pre-term newborn infant and for the infant born with conditions that needs intensive care.

Examples of such infants are:

1. Babies born to diabetic or drug-addicted mothers.

2. Infants whose mothers suffered severe blood poisoning associated with pregnancy.

3. Infants born by Caesarean section because of a variety of complications.

4. Low birth weight infants born pre-term or at term.

5. Infants with infection, post-delivery distress or cardiac, respiratory or gastro-intestinal problems.

6. Infants with congenital defects requiring immediate treatment, such as heart malformation or gastro-intestinal blockage (Jonson 1976).

Some of the medical problems of the premature baby

Most very premature babies need help in breathing. Their lungs are ventilated for between a few hours and a few weeks depending on the immaturity of the lungs. Most babies recover, their lungs develop and ventilation is ended. Some with severe lung illness die as a result of this condition (Mayes et al, 1985, Morley 1987). Most babies stay on an Intensive Care routine and then on a
Special Care routine till their birth date: thus a baby born 10 weeks prematurely will be on the Unit for about 10 weeks.

Maintaining premature infant body heat is difficult and very important to the survival of the baby. He has a large surface area relative to his body mass and therefore can lose body heat very quickly. This can lead to many complications (Fleming, 1985).

There is a risk of brain injury caused by haemorrhage in the neo-natal period of the infant's life that may cause long term neuro-developmental disabilities. This damage can be predicted now more clearly with the help of the ultrasound check up (Stewart et al, 1987). The damage to the central nervous system in a pre-term infant may lead to motor impairment, cognitive and learning disorders, visual and hearing impairment. The motor impairment can range from minimal disability to severe paralysis. Learning difficulties are present and speech delay is common but reversible (Wyatt and Spencer 1992). There is a risk of loss of sight. This used to be thought to be linked to excessive use of oxygen in babies with lung disease (Kinsey et al, 1956). However when, due to developments in the 1970s many more very premature babies survived, retinopathy of prematurity reappeared. It seems this is not preventable by the correct use of oxygen only (Phelps, 1992).

There are also for the premature infant risks of loss of hearing, heart defects, anaemia and jaundice.
To sum up:

The concerns of the Director seemed to me to be justified. It was difficult to see how the team could discharge its duties.

The task stated in a theoretical way was to try to move the team from living in a part object world using splitting, idealisations and denial, to one living and functioning in the depressive positions linked to reality, acknowledging facts, and being able to be separate from patients and their families while still caring for them. Below I shall attempt to chart the process of this journey of change.

1.1 Review of the literature: Psycho-Analytic discoveries

Introduction

In this, and the following sections of this chapter I look at the theoretical foundations of the work which have been shaped by a number of ideas and concepts from three main fields:

1. Psycho-Analytic discoveries.

2. Work on Institutions.

3. Psychological investigations in the Neo-natal field.
Freud's discoveries in the field of group psychology.

The ego

What is the nature of a group and what makes it function? What, when it is missing makes the group disfunction or disintegrate? Some of these questions are dealt with below.

The psycho-analytic work on groups is anchored in Freud's ideas about the ego and its transformation. It is at the beginning of the second topographical theory where the ego is seen as the seat of psychical conflicts between the super-ego prohibitions and the id representing the instinctual forces. "It does mean that functions, which were distributed between several systems in the first scheme of things are now to be found together within the agency of the ego" (Laplanche and Pontalis, 1980).

From Freud's paper "On Narcissism: an Introduction" (1914), the ego is seen as capable of identifying itself with a love object, presenting itself as a love object, having an "observing agency" and as having an ego ideal as a result of the process of identification.

This view of the ego as a complex organisation able to have internal conflict and to split into various parts, is important in a number of other fields, however in this instance I looked at the ego as seen in three other publications, "Totem and Taboo", "Mourning and Melancholia" and "The ego and the Id".

The importance of the change in the ego as a result of identification with an object is beautifully described in "Mourning and Melancholia". Earlier in "Totem and Taboo"
(1912) Freud writes about the "primal horde": a group of brothers who are ruled by a tyrannical father whom they kill and eat, thus incorporating the father's strength into themselves.

A similar process of incorporating the father's perceived strength is achieved in a led group, not by eating the leader, but by introjective identification. The leader of the group is submitted to as if he has taken the place of the original father in the members' egos. He replaces their egos' ideal.

The libidinal force that binds members of a group

An important discovery that Freud makes in his book "Group Psychology and the Analysis of the Ego" is that the group is held together by libidinal force. "Our hypothesis finds support in the first instance from two passing thoughts. First, that a group is clearly held together by a power of some kind; and to what power could this be better ascribed than to Eros, which holds together everything in the world? Secondly, that if an individual gives up his distinctiveness in a group and lets its other members influence him by suggestion, it gives one the impression that he does it because he feels the need of being in harmony with them rather than in opposition to them."(S.E.18).

It is necessary to take on board the idea that it is the emotional "glue" that is the all-important phenomenon. Its components make for a stronger or weaker group. This emotional force is driven by the process of identification described in the earlier publications, one of which is "Mourning and Melancholia" in which Freud describes
identification as the process where "the shadow of the objects falls on the ego" (S.E.14).

Identification

Identification is the process at the centre of the emotional tie in groups. It is via identification that the member's ego is transformed and two new links are formed: to the leader, and to the other members of the group.

Ideas on the origin of identification are explored in "Totem and Taboo", interpreted as a process based on cannibalistic devouring, "One day the brothers who had been driven out came together, killed and devoured their father and so made an end of the patriarchal horde. United, they had the courage to do and succeeded in doing what would have been impossible for them individually" (S.E.13 1913). Killing and eating the strong envied father, was the original way in which the brothers acquired some of their father's abilities.

In "Mourning and Melancholia" Freud states that the nature of the identification is based on the oral mode: the subject regresses and takes the lost object into his ego. The libido that was removed from the lost object did not attach itself to a new one, but moved into the ego. "There, however, it was not employed in any unspecified way, but served to establish an identification of the ego with the abandoned object. Thus the shadow of the object fell upon the ego, and the latter could henceforth be judged by a special agency as though it were an object, the forsaken object. In this way an object-loss was transformed into an ego-loss and the conflict between the ego and the loved person into a cleavage between the
critical activity of the ego and the ego as altered by identification" (S.E. 14).

This process is looked at in other works, for example "The Oedipus Complex" in which the boy identifies himself with his father (S.E. 19), and in "On Narcissism: an Introduction", in which Freud describes the narcissistic object choice: where the subject chosen is an object modelled on the subject self.

Identification in Groups

The process of identification of members of a group with its leader and with each other is developed by Freud in "Group psychology" (1921 S.E 18). The editor states in the introduction, "The work is important in two different directions. On the one hand it explains the psychology of groups on the basis of changes in the psychology of the individual mind. And on the other hand it carries a stage further Freud's investigation of the anatomical structure of the mind which was already foreshadowed in Beyond the Pleasure Principle (1920) and was more completely worked out in The Ego and the Id (1923)."

The force at the centre of group life is the issue I found most relevant to the work with the team on the Neo-natal Unit. Freud offers an original powerful concept that is at the centre of much further development in psycho-analytic work with groups.

Freud states that the emotional tie of love is at the centre of artificial, organised groups such as the Catholic church and the army. Members of these groups love their leader, believing that he loves them equally in return. The illusion of this bond is an essential fact
of the group's life. Freud states: "Everything depends upon this illusion; if it were to be dropped, then both Church and army would dissolve, so far as the external force permitted them to" (S.E.18). Members of the groups would be exposed to an attack of panic if, and when the mutual ties break. "A gigantic and senseless fear is then set free, as in the neurotic anxiety" (P 97). Christ is seen as an elder brother to the group of believers, he is a father-substitute, before Christ everyone is equal, and everyone has an equal share in his love. It is not without a good reason that the similarity between the Christian community and a family is invoked, and that believers call themselves "Brothers in Christ", that is brothers through the love which Christ has for them. There is no doubt that the tie which unites each individual with Christ is also the cause of the tie which unites them with one another. Similar feelings occur in a group of soldiers in relation to their commander, and between themselves. They view people who are not attached by the same double bond as strangers, inferior and possible enemies.

The group libidinal tie operates via Identification. Tracing identification in the resolution of the Oedipal conflict, in "Hysterics" (Dora) and "Depressives" (Mourning and Melancholia) and in "Narcissism" Freud states firstly, "Identification is the original form of emotional tie with an object; secondly, in a regressive way it becomes a substitute for a libidinal object-tie, as it were by means of introjection of the object into the ego; and thirdly, it may arise with any new perception of a common quality shared with some other person who is not an object of the sexual instinct. The more important this common quality is, the more successful may this partial
identification become, and it may thus represent the beginning of a new tie." (p 108)

Using Ferenczi's concept of introjection (1916) Freud defines the led group as "a number of individuals who have put one and the same object in the place of their ego ideal and have consequently identified themselves with one another in their ego. An introjective identification has taken place in each member's ego."

It seems to me that the Identification process Freud describes, uses among others, the process of introjection. An individual who took into his ego the identity of the leader, by introjection has the experience that his ego has been altered. He talks, behaves and feels himself to have become a different human being.

Discussion

A Neo-natal Unit can be seen as a number of groups interacting with each other. At the core there is an assumption, or an illusion that the members of staff "love" and care for their patients, and care for each other and the Unit. A further assumption is that the parents care about their babies and about each other. If these assumptions are no longer in place a terrible fear can and does erupt. Paranoid feelings about the safety of the place and the future of the babies can and do arise.

It was during one such occasion in the life of the Unit that I was called in to help (see Chapter 3). A baby was left to die and the staff identified with, and maybe confused by the dying infant, panicked. The Unit was in
crisis. Staff were seen by their Manager as forever running, as if fleeing from a dangerous environment.

I found Freud's writing about the processes at the core of group life very relevant to the life of the groups I saw and worked with in the Unit. The illusion of a relation to the leader and to each other is at the heart of the life of the group: without it the group will panic, a "gigantic and senseless fear is then set free" (Freud, 1923) and the group disintegrates.

When and how does the group that works on the Neo-natal Unit suffer a sense of loss of the special relationship to the leader, or more to the point, when is there a sense of loss of the leader's love, which leads according to Freud, to a collapse of the working group.

There are tragedies on the Unit: babies die in such units every month, sometimes more often. However it is only on some of these occasions that a sense of panic takes over and the team is at risk of disintegration. I wondered if on these occasions the team is confused unconsciously with the dead infant who has lost his life by losing his parents'/leaders' love which is felt to be life-supporting. Is it possible to think of an unconscious group phantasy that equates a living baby with a loved one, one who has a special relationship to his parents? The tragedy then becomes a threat to the cohesive team: we do not have an identification, but a symbolic equation (Segal, 1981) of the team with the baby who lost his parents' love that caused his death.
1.2 Anxieties and defences

Anxieties seen in the Neo-natal Unit's staff, are examined in Chapters 3 and 4. Some of the theoretical understanding of the clinical data is put forward in this section. Psychoanalytic understanding of group life i.e. the anxieties felt, and defences used by its members was further extended by Freud's followers. Further steps following Freud's discoveries were made by, among others, Ferenczi on projections and introjections: Klein on early anxieties and defences in her work on the paranoid and depressive position and projective identification, the latter developed further by Bion.

In Chapters 5 and 6 I look at the types of anxieties experienced by parents of premature infants. It seemed to me that the "adult" parts of some of the parents become traumatised. A "premature parent" is revealed, and very early anxieties and defences are uncovered. The theoretical issues of this clinical picture are considered briefly in Chapter 5 Section 2.

Ferenczi, in his paper "Introjection and Transference" (1916) links the transference, which he describes as one of Freud's most important discoveries, to projection and introjection in everyday life. Introjection is a fundamental characteristic of the neurotic, and
projection the characteristic of the paranoic. "Whereas
the paranoic expels from his ego the impulses that have
become unpleasant, the neurotic helps himself by taking
into the ego as large as possible a part of the outer
world, making it the object of unconscious
phantasies...one might give to this process, in contrast
to projection the name of introjection." This process
starts according to Ferenczi in infancy. "The first loving
and hating is a transference of auto-erotic pleasant and
unpleasant feelings on to the objects that evoke those
feelings. The first "object-love" and first "object-hate"
are, so to speak, the primordial transferences, the roots
of every future introjection."

The paranoid-schizoid position

The paranoid schizoid position refers to the emotional
experience of the first 4 months of the life of a baby.
Klein detailed the anxieties and defences that confront
the infant from birth. The anxiety, which is the
expression of the death instinct, is felt from birth, and
is projected on to the mother's breast, and then
reintrojected. The baby, suggests Klein, feels this as a
fear of annihilation. This projection is at the core of
the infant's first persecutory bad object. This bad object
has acquired the oral destructive qualities of the
infant's own impulses when he is in a state of frustration
and hatred. "In his destructive phantasies he bites and
tears up the breast, devours it, annihilates it, and then

- 24 -
feels that the breast will attack him in the same way. The 
good, or idealised relationship to the feeding and 
protecting breast is at the core of the infant's good-
idealised object, always available, gratifying and 
inexhaustible. The baby projects its good feelings into 
the first part object and introjects them reinforced, and 
thus its internal good and bad objects come into being.

The first object relation starts with the infant's first 
experience of his mother and of feeding (1952). Both 
libidinal and aggressive impulses are directed at the 
first part object. "The recurrent experiences of 
gratification and frustration are powerful stimuli for 
libidinal and destructive impulses, for love and hatred" 
(P. 62). As the ego is very weak and unable to cope with 
the powerful anxieties it uses splitting, denial of 
reality and idealisation, and control of its object as 
its defences by projective and introjective 
identification.

These first introjects form the core of the infants' super 
ego.

The depressive position

Changes influencing both ego and object take place towards 
the middle of the first year of life. The infant regards 
the mother as a whole object: splitting her into good and 
bad parts diminishes. At the same time the gap between

- 25 -
internal and external object and reality is narrowing, and love and hate impulses come much closer together. The anxiety in this stage of development changes from the paranoid fear of being attacked by the persecutor, to the fear of losing the internal and external objects.

The ego can resort to paranoid defences or more relevant to this position, to the drive to inhibit aggressive impulses and to make reparation: "The anxiety relating to the internalized mother who is felt to be injured, suffering, in danger of being annihilated or already annihilated and lost for ever, leads to a stronger identification with the injured object. This identification reinforces both the drive to make reparation and the ego's attempts to inhibit aggressive impulses. The ego also again and again makes use of the manic defence: denial, idealization, splitting and control of internal and external objects...These are in some measure, maintained when the depressive position arises but they are now predominantly used in order to counteract depressive anxiety. ..they become less extreme and correspond more to the growing capacity of the ego to face psychic reality" (1952).

The reparative drive develops as a result of a sense of guilt which comes from the phantasised attacks on the object: "At this stage, the drive to make reparation to the injured object comes into full play. This tendency, as we have seen earlier, is inextricably loaded with feelings
of guilt. When the infant feels that his destructive impulses and phantasies are directed against the complete person of his loved object, guilt arises in full strength and, together with it, the over-riding urge to repair, preserve or revive the loved, injured object. These emotions in my view amount to a state of mourning, and the defences operating amount to attempts on the part of the ego to overcome mourning" (P74 "The emotional life of the Infant").

The pioneering work of Bion

One of the most creative and influential thinkers in the field of group behaviour was Bion. His work on the attacks on links, and attacks on thinking that centres around the development of the concept of projective identification (in the work on the Container Contained model) proved to be central to my work (Learning from Experience).

When in charge of the Training Wing in Northfield hospital, and exposed to a barrage of requests and queries from NCOs and patients he soon came to the conclusion that what was needed was discipline. He thought that "the discipline required depends on two main factors: 1, the presence of the enemy, who provided a common danger and a common aim and 2, the presence of an officer who, being experienced, knows some of his own failings, respects the integrity of his men, and is not afraid of either their
good-will or their hostility" (Experiences in Groups 1961).

He thought that the enemy in the hospital that could unite the unit was "the existence of neurosis as a disability of the community. What was needed was a display of the neurosis as a danger to the group and its display must somehow be made the common aim of the group" (1961).

This was the background to the Northfield experiment. This experiment, which became the foundation for a comprehensive theory of group life, consisted of a framework of activities: every soldier had to belong to one or more groups doing map-reading, carpentry etc. New groups could be started by the men, and those who felt unable to join could go to the rest room. There was a midday parade for men to step outside their framework and look upon it with the detachment of spectators. Bion reports some results. His determination not to attempt the solution of any problem until it became clearly defined helped to produce a real belief that the unit was meant to tackle its job with scientific seriousness. The training group became more self-critical, the patients took more initiative and responsibility. Morale improved and the cleanliness of the unit was better, despite established patients leaving and new ones coming in. The conclusions from this experiment were:
"We are now in a better position to define the "good group spirit" ...it is as hard to define as is the concept of good health in an individual, but some of its qualities appear to be associated with:

a. A common purpose, whether that be overcoming an enemy or defending and fostering an ideal or a creative construction in the field of social relationships.

b. Common recognition by members of the group of the "boundaries" of the group and their position and function in relation to those of larger units or groups.

c. The capacity to absorb new members, and to lose members without fear of losing group individuality i.e. group character must be flexible.

d. Freedom from internal sub-groups having rigid boundaries.

e. Each individual member being valued for his contribution to the group and having free movement within it.

f. The capacity to face discontent within the group and to have the means to cope with discontent.
Bion's theory on groups

In his book "Experiences in Groups" (1968) Bion describes the group work he started at the Tavistock Clinic. Having taken groups of patients and having tried to persuade them to make the study of their tensions a group task, he then was asked to take "therapeutic" groups.

Bion describes his behaviour in the group as that of an analyst who highlighted the group unconscious phantasies about him.

The first thing which is apparent is that he thinks of the group as the patient. Bion gives an account of what was said in the group and comes to the conclusion that: "Judged by ordinary standards of social intercourse, the performance of the group is almost devoid of intellectual content. Furthermore, if we note how assumptions pass unchallenged as statements of fact, and are accepted as such it seems clear that critical judgment is almost entirely absent." (1961)

The theories on basic assumptions

He developed his seminal theories about what are the unconscious phantasies that govern and control this
phenomenon of a group devoid of almost all intellectual ability. He noticed that such a group will tolerate silently a pair of members talking to each other. He suggested that the pair and the group held an assumption that something sexual is taking place and the group allows this to go on indefinitely.

Bion developed the view that basic assumptions that are unconsciously held by all members of the group influence and direct the life of the group. Bion writes that a particular emotional state leads to a particular basic assumption which governs group life at any one time and that there are three emotional states each leading to a particular basic assumption. The three basic assumptions are Dependency, Pairing and Fight flight.

Dependency

Bion writes about groups of patients and their relationship to their psychiatrist. The patients feel "treated" or "fed" only when they relate to the doctor. "The dependent group, with its characteristic elevation of one person, creates difficulties for the ambitious, or indeed for anyone who wishes to get a hearing, because it means that in the eyes of the group, and of themselves, such people are in a position of rivalry with the leader. Benefit is no longer felt to come from the group, but from the leader of the group alone, with the result that individuals feel they are being related to only when
talking to the leader of the group" (ibid). The members therefore behave and feel that they have nothing of value to say and it is the leader who by "magic" can solve all their problems. This basic assumption means that the group is hostile to any learning as its basic belief is in the omnipotence of its leader.

The leader can be a person or a belief ("the bible" of the group), whose task is to protect the group from any contact with reality. When the leader does not fulfil the group's needs, he is rejected or ignored. The group then will appoint another leader, usually the sickest member of the group. The group can then split into two sub-groups: one will ensure that support for the leader, (be it an idea, a person or a bible) demands no sacrifice, therefore becomes popular but stale and dogmatic; the other sub-group will manipulate the leader so that membership becomes so difficult that no one will wish to join the group. The purpose in both cases is the same, to prevent reality intruding into their phantasies.

**Pairing**

When a group is in this state it is usually filled with hope for a Messiah who will be born and save the group from its problems and its anxieties. The hope exists only as long as the leader, whether Messiah or idea, remains unborn. If the group develops a leader, hope is weakened. The leader will fail to rescue the group from its
difficulties with its own feelings of hate, despair and destructiveness. "Hope in the pairing group is a function of the basic assumption and cannot be regarded as a sign of individual development" (ibid). The function of this basic assumption is again to keep the group away from the reality of what is actually taking place and keep it "dreaming" about a future rescue in the shape of an idea, a Messiah or Utopia.

**Fight Flight**

"The third basic assumption is that the group has met to fight something or to run away from it. It is prepared to do either indifferently" (ibid). This is a group governed by paranoia. A leader must lead the group against the "enemy" or help create the enemy. The leader is the creature of the group and has no more freedom to be himself than any other member of the group. "The loss of individual distinctiveness applies to the leader of the group as much as to anyone else - a fact that probably accounts for some of the posturing to which leading figures are prone. Thus the leader in the fight flight group, for example, appears to have a distinctive personality because his personality is of a kind that lends itself to exploitation by the group demand for a leader who requires of it only a capacity for fighting or for flight. Again the group is unable to face reality
because it might have to face the painful fact that the enemy is inside it."

Basic assumption participation is achieved instantaneously and instinctively. It makes no demands of the individual for a capacity to co-operate, instead the individual is meant to share and act on a basic assumption. This mentality does not allow for development. Time is imperfectly recognized. Development is linked to reality and insight is possible only if the group has an "ego" that functions sufficiently in contact with reality. The basic assumption phenomena are defences against reality, therefore a group reacts with a sense of persecution when interpretations reveal its disturbed relationship to time or development.

All three basic assumption defences are linked aspects of the Oedipal conflict, operating on a part level relationship. "It will now be seen from this description that the basic assumptions now emerge as formations secondary to an extremely early primal scene worked out on a level of part objects and associated with psychotic anxiety and mechanisms of splitting and projective identification such as Melanie Klein has described as characteristic of the paranoid-schizoid and depressive positions. Introjection and projection of the group which is now the investigator, now the feared object of investigation, form an essential part of the picture and
help to add confusion to the scene unless recognised as being very active" (ibid).

The more disturbed the group is the more easily available are the primitive part object phantasies. It seems that the groups of staff or parents in the Neo-natal Unit are exposed to very disturbing experiences that reinforce the part object psychotic phantasies.

The Work Group

A group containing the same members can function at different times either as a basic assumption group or as a work group. The work group is doing what the ego does in the individual, positioned between external reality and the self.

Members of a work group meet to "do" something. They have to co-operate: this is related to having to be organized and having a formal structure. "Work group" is a term that defines the mental activity of the group: members are aware that they have to learn and develop both their personal and inter-personal skills. The work group is an open system and facilitates development. It is constantly perturbed by influences which come from other group mental life.

Bion stated that man is fundamentally a group being. "The adult must establish contact with the emotional life of
the group in which he lives, this task would appear to be as formidable to the adult as the relationship to the breast appears to be to the infant, and the failure to meet the demands of this task is revealed in his regression. The belief that a group exists, as distinct from an aggregate of individuals, is an essential part of this regression, as are also the characteristics with which the supposed group is endowed by the individual." (1952) Bion also believed in the triumph of the work group over the basic assumption group, "I think one of the striking things about a group is that despite the influence of the basic assumptions, it is the work group that triumphs in the long run." (1968)

According to Klein, paranoid anxieties linked to the operation of the death instinct from birth and defences of splitting idealisation and denial of psychic truth are at the basic core of a baby's relationship to its first object. At the same time the idealised object forms the basis of the good nursing object which the infant introjects into his young and still weak ego.

Bion showed that processes similar to the ones Klein described operating in the life of the young infant, operate in the unconscious life of the group.

- 36 -
1.3 Organization as a defence against anxiety

Introduction

The first meeting I had with the Management of the Midwifery Service of the Health Authority at the start of this project, was devoted to looking at the worries the Manager had about the Neo-natal Unit: One nurse was a particular source of worry, the Manager felt that she needed some help. The other more general concern was that the unit was not functioning properly (Chapters 2 and 3). This section looks at the theories that explore the relationship between the unconscious anxiety of the individual and the changing of the structure of an organisation in order to provide some respite for the individual member. The organisation has to "bend" like a plant towards the light, in order to survive so that the tasks it is set are discharged. Chapter 3 looks at my attempt at "bending" the organisation in an attempt to provide alternative sources of support for the individual so that the organisation could begin to function in a somewhat different way.

The Work of Elliot Jaques

Following Klein's work on early anxieties and defences and Bion's discoveries that group life can be overwhelmed by unconscious projections of its members' anxieties, Jaques developed the idea that institutions are at times used by their members as a defence. Jaques a Canadian psychiatrist and psychoanalyst joined the Tavistock Institute and played an important role in the five years that he stayed there. In his paper "Social Systems as
Defence Against Persecutory and Depressive Anxiety" he states: "One specific hypothesis I shall consider is that one of the primary cohesive elements binding individuals into institutionalised human association is that of defence against psychotic anxiety. In this sense individuals may be thought of as externalising those impulses and internal objects that would otherwise give rise to psychotic anxiety, and pooling them in the life of the social institutions in which they associate. This is not to say that the institutions so used thereby become "psychotic" but it does imply that we would expect to find in group relationships, manifestations of unreality, splitting, hostility, suspicion, and other forms of maladaptive behaviour" (1955).

Jaques states that if his ideas are correct then the resistance to change in social, economic and political situations can be interpreted as individuals defending themselves against psychotic anxieties linked to change in their defences rather to human ignorance, stupidity, wrong attitudes or power seeking.

Social defences against psychotic anxieties

Drawing on Freud's Group psychology and the analysis of the ego, Jaques describes the mechanism of projective and introjective identification that is at the core of group cohesiveness. Members of groups identify with their leader by introjection. Their replacing of their ego ideal by an external object seems, to Jaques, to imply the process of projective identification: "Indeed it is just such an extreme of projective identification which might explain the case of panic described by Freud where the Assyrians take to flight on learning that Holofernes, their leader, has had his head cut off by Judith. For not
only has the commonly shared external object (the figure-head) binding them all together been lost, but also through the leader having lost his head, every soldier has lost his head through being inside the leader by projective identification"(ibid).

Jaques then shows how projection, introjection, identification and splitting in social relationships are used by the individual in defence against paranoid anxieties. An object for projection then facilitates the development of what Jaques calls "phantasy social relationships"(ibid).

Jaques illustrates this in the case of the First Officer of a ship who is held by the crew to be responsible for all the problems of the ship, thus making him into the bad object and the container of the bad impulses of the crew. The Captain is seen as the good or ideal figure containing the good impulses of the crew. The crew then find relief from the bad impulses and the idealised Captain is saved from their anal attack. The First Officer is often seen as "having to take all the shit and must be prepared to be a shit".

Jaques calls this the process of absorption, meaning the First Officer absorbs the projections. Another process, that of deflection, is seen in a nation at war: the bad, sadistic, cruel, impulses are commonly projected into the enemy's army, who when attacking back, is feared as the object that contains the projected bad impulses.

A defence against depressive anxieties

The hallmark of the depressive position is an awareness that the same object has good and bad aspects, and the
subject is loving and hating the one object. Jaques sees, in a majority persecuting a minority an attempt by the majority to project and get rid of its awareness of its destructiveness. Guilt is avoided by contempt of and attacks on the scapegoated group (ibid).

The other social mechanism illustrated through manic denial of destructiveness and group idealization is seen according to Jaques in mourning ceremonies. "Bad objects and impulses are got rid of by unconscious projection into the corpse, disguised by the decoration of the corpse, and safely put out of the way through projective identification with the dead during the burial ceremony" (ibid).

The social system as a defence against anxiety in a hospital

This is Menzies Lyth's famous work on the Nursing Service of a General Teaching Hospital in London: the Hospital had 700 Nurses, 550 of whom were Student Nurses. The presenting problem Menzies Lyth had to address was the conflict between the needs of the Student Nurses towards their training and the need of the Hospital to care for its patients. The sense of crisis felt by the senior Nursing staff was fuelled by the realisation that the system of student allocation that existed meant that some students might finish their four-year training without experience in some areas.

The relationship between the Hospital and Menzies Lyth is described as "socio-therapeutic" and early on it was decided to regard the allocation problem as a presenting problem, namely it was the socially acceptable problem which may be the symptom leading to a more hidden as yet
undefined problem. Diagnostic work was carried out through interviews, observations and discussions, both formal and informal. As the diagnostic work progressed, researchers found a high level of tension, distress and anxiety among Nurses. The diagnostic phase concluded that understanding and reducing the level of anxiety was the therapeutic task of the work, and it proved to be closely related to developing more effective techniques of student nurse allocation.

The nature of the anxiety

Menzies Lyth unveils for us the nature of the Nurses' anxieties that are an inevitable part of her work. "The primary task of the Hospital is to care for people that cannot care for themselves; and this service is mainly provided by the Nursing staff 24 hours a day, all year around. Nurses are confronted with the threat and the reality of suffering and death as few lay people are. Their work involves carrying out tasks which by ordinary standards, are distasteful, disgusting and frightening. Intimate physical contact with patients arouses strong libidinal and erotic wishes and impulses that may be difficult to control. The work situation arouses very strong and mixed feelings in the Nurse: pity, compassion and love, guilt and anxiety, hatred and resentment of the patients who arouse these strong feelings, envy of the care given to the patient" (ibid).

Menzies Lyth states that the work of the Nurse often mirrors her unconscious paranoid and depressive anxieties about her internal world and its objects, which in turn increases her anxiety in dealing with the external situation.
The similarity of the external situation to the unconscious phantasies makes it difficult for the Nurse to use symbolisation in order to control anxiety. The Nurse projects her unconscious anxiety on the external situation and reintrojects it. Thus the external situation becomes worse as it becomes fused with unconscious anxiety. The nature of the Nurse's work puts her at risk of being flooded by unmanageable anxiety, but it is the defensive techniques in the Nursing Service, according to Menzies Lyth that make a difficult situation worse.

Defensive techniques

Menzies Lyth states that individuals belonging to an organization will externalise their anxiety and use the institution for their defence system. Over time a defence system will develop which will be perceived as part and parcel of the external reality of the organisation that new members coming to it will have to come to terms with. Menzies Lyth then lists many defences, used in the organisation of the hospital. Firstly, splitting the nurse-patient relationship: in order to avoid a close relation to any individual patient the Nurse performs tasks for all the patients on her ward. This task-list way of working prevents the development of person-to-person relations. It produces a de-personalisation or elimination of individual distinctiveness in both patient and Nurse. The social system in the Hospital was created originally by people lacking an ability to change. It became rigid and fixed. New student Nurses had to introject it which resulted in the new student experiencing a considerable degree of pathological anxiety. The Hospital system was not only failing to develop the Nurses' ability to deal with anxiety, but in many cases it forced the individual to regress to a maturation level below that which she had
achieved before she entered the hospital (Menzies Lyth 1970).

**Difference in my role in the organisation**

The role of the consultant, as described in Menzies Lyth's important papers "The functioning of social systems as a defence against anxiety" (1950) and "Action research in a long-stay hospital" (1973) is fundamental to Menzies Lyth's work and to that of many other workers who came from the Tavistock Institute and followed the research pattern of Kurt Lewin. It is however somewhat different to the role which I played in the Neo-natal Unit.

Having formed some ideas on the nature of the difficulties of the institution and its members I instigated some changes in the structure, but felt that was not sufficient. Units such as this have a need for some therapeutic input that has to become part of their structure, an integral part of the service. The level of stress in such units calls for a different model of intervention from that of the outside consultant. I return to this issue in Chapter 8.
1.4 Action research
The work of Kurt Lewin

Introduction: "Involvement in Change"

In Chapter 3 I describe the first stage of this project: the assessment of the problems on the Unit. I aim to show the way I involved the Management of the Neo-natal Service in the change, which they felt was needed. It was agreed that the observations I made and the knowledge thus produced would be shared: reflections and planning then took place in meetings I had with the Management. This was a crucial stage of this project. I felt that without the collaborative attitude that was generated, this project could not have proceeded.

The sharing of knowledge acquired during discussions with parents is also a central function of the clinical seminar I had with the staff. I found the sharing of knowledge to be a very slow and difficult process. For example the presenting problem at one meeting was the difficulties the Doctors have in communicating with bereaved parents. I tried to convey the notion that parents might "hear" what the Doctors were saying as an accusatory statement. This was difficult for the Doctors to accept. The case discussed at that meeting was that of a baby that had died after 5 months on the Unit. The Doctor had told the parents that their baby had had "the worst pair of lungs" he had seen in 15 years. I believe the parents might have interpreted this as the Doctor accusing them of producing "a damaged pair of lungs". The Doctor in turn might have interpreted this suggestion from me as questioning his ability to be sensitive to the sufferings of his patients.
The ideas of Lewin, as developed in his writing on action research were enormously useful in the assessment stage and in the work in the group in this project. However the type and level of anxieties met on the Unit meant that theories and ideas on paranoid anxieties and defences had also to be incorporated into the theoretical framework of this work.

The term "Action Research" was coined by Kurt Lewin, (a Jewish German psychologist, 1890-1947). It is discussed in his papers published between 1947-1952. The main characteristic of this research methodology is its focus on the "involvement in change"; it links to a need to solve a problem, usually a social, practical one rather than a theoretical question. It has a collaborative characteristic in as much as it generates knowledge that is produced and shared in the setting in which the research is taking place.

Kurt Lewin had great personal influence through the applied research institutions that he established e.g. the Committee on Community Interrelation (CCI) and the Centre for Group Dynamics (CGD). One of Lewin's primary objectives was to close the gap between abstract social theory and particular concrete field work: action research was intended to solve a concrete problem such as racial prejudice and discover "general laws of group life".

Lewin conducted controlled empirical research that was inspired by among other theories, that of psychoanalysis. "From these efforts, psychoanalysis received a graver lustre of investigative respectability and this in turn led other more conventional psychologists to conduct related research"(Hall & Lindzey, 1968). According to
Robert de Board, it shows a passionate concern for democracy in general, and minorities in particular. "Even greater than this was his desire to make psychology an applied science, something that would change and improve the social conditions of men and women. As a German Jew he was forced to leave Germany and flee from the Nazis in 1933. Lewin believed that social psychology based on an intimate combination of experiments and empirical theory could do as much or more, for human betterment than the natural sciences have done." (de Board 1978)

In the 1920s Lewin wrote that "every job has a life value" meaning that work has to sustain and enhance. The task to accomplish this cannot be achieved by the efficiency expert alone. Lewin brought his research methodology into the mass production field, for example looking at an American factory. Many others followed.

For Lewin, action research provided a way both to solve practical problems, such as racial prejudice, and to discover "general laws of group life... A knowledge of group laws is, however, insufficient for the resolution of a social problem. One must supplement this knowledge with knowledge of the specific character of the situation, which, through a process of scientific fact finding is called diagnosis" (Lewin 1948). He describes the stages of the action research cycle: the diagnostic stage of fact finding, reflection and planning which together with relevant laws produces a change strategy. This is followed by an action and evaluation stage.

In the first issue of the Human Relation Journal which he founded with Trist, he writes:
"One of the by-products of World War 2 of which society is hardly aware is the new stage of development which the social sciences have reached. This development indeed may prove to be as revolutionary as the atom bomb. Applying cultural anthropology to modern rather than "primitive" culture, experimentation with groups inside and outside the laboratory, the measurement of socio-psychological aspects of large social bodies, the combination of economic, cultural and psychological fact finding, all of these developments started before the war. But by providing unprecedented facilities and by demanding realistic and workable solutions to scientific problems, the war has accelerated greatly the change of social sciences to a new development level. The scientific aspects of this development centre around three objectives:

1. Integrating social sciences.

2. Moving from the description of social bodies to dynamic problems of changing group life.

3. Developing new instruments and techniques of social research" (Human Relation Journal 1).

He argues that social events were treated in the past as non-existent, or as unscientific phenomena that could not be explored. They were a scientific taboo, like a social taboo and any investigation of them was seen to be in opposition to the scientific common belief. He developed the concept of "field of force" and "life space", and applied these to the way groups behave. One of his most important works was in the field of mass production, exemplified by action research in a pyjama factory.
Experience in Action research

Lewin visited a pyjama factory that employed young women in Marion, Virginia. He had previously shown how group democracy enhances productivity, and helped Bavelas to develop the famous experiment that showed how productivity rose with the introduction of a more democratic way of managing the work.

The productivity of one group of workers, who paced their hourly work by using "pacing cards" rose from 67 units to 82 units, while the control group's productivity stayed the same.

Later the factory had to move, and an experiment devised by Coch and French showed that the involved group of workers (who had been consulted throughout the move) reached the pre-move productivity level after only two days. Levels of 14% higher productivity were recorded later and were maintained. In the other group of workers (who were merely informed about the move) a reduction of output was recorded, and 17% of workers subsequently left the factory (Human Relation Journal, 1948,1).

Sharing information in the Neo-natal Unit:

The Neo-natal Unit divides into two main groups: staff and parents. These then sub-divide further, for example into Medical and Nursing staff, which again sub-divide along lines of seniority. The notion of consulting staff and involving them in what takes place around them is very popular, at least officially, and medical decisions are shared with Nursing staff. However the example below
illustrates the exclusion of the parents from the sharing of information.

One mother spent three months on the Unit, visiting her baby who was very ill. She had got to know another mother who had a very sick baby girl. The second baby died. The first mother complained in the Parents Meeting that the death had been kept a secret. Staff did not tell her: she had seen a great commotion, people running and she had understood but she had wanted to be informed. She wanted to send a card or attend the funeral. This came up in a Staff Meeting. Should she have been told or not? Do mothers who spend months on the Unit become almost part of an artificial family and should therefore be told what is going on rather than discover it?

It became clear that the staff had never thought about this. One nurse told us that she supposed that it was never talked about. Years ago when she was training on an adult ward, when a patient died the curtains were closed and when asked by another patient where he was, she was told to say that he had been moved to another ward. Death did not exist.

Some members of staff felt that there was an issue of confidentiality here; some thought that you cannot hide a death: it is no longer a private matter.

I feel that Lewin's theories do not take on board the dynamic issues that are alive here. The fact is that babies do die on the Unit, and staff can no longer pretend to themselves or to parents that all babies are saved. One mother (who had herself nearly died) almost accused the
staff of denying this and of hiding the truth. She was not prepared to be patronised.

Issues of life and death, of babies surviving or not, need a theory that takes on board paranoid anxieties and primitive defences. I thought that in order to get mothers and staff to think about these issues I needed not only action research theories, but also theories on early anxieties and early defences.

The training groups

From 1944 Lewin became more and more interested in Group issues. In his new centre based in the Massachusetts Institute of Technology, he studied group dynamics with many colleagues (Cartwright, Lippitt, McGregor, Allport). The Centre explored issues such as: anti-semitism in every aspect of social life, the employment of negroes on sale counters, and gang fights.

Perhaps's Lewin's most enduring achievement was the creation of the "T groups". These training groups were the model for many groups training in America and elsewhere in the world, including the Tavistock-Leicester conferences (Sofer and Trist, 1959).

In 1946 Lewin organised and directed a conference to look at the most useful way to counter religious and racial prejudices. This, the Connecticut Conference, comprised 30 members including teachers, social workers, labour leaders and a businessman. The Conference divided into three groups of ten. Through role-plays and group discussions social issues were looked at. Lewin led the team of
researchers and Lippitt, Bradford and Benne were the training leaders.

The trainers concluded that they had found an effective way to retrain. "Group members, if they were confronted more or less objectively with data concerning their own behaviour and its effects, and if they came to participate non defensibly in thinking about these data, might achieve highly meaningful learnings about themselves, about the responses of others to them, and about group behaviour and group development in general" (Bradford, Gibb and Benne, 1964). Further references to action research are to be found in work on Social and Community Action: Ketterer, Price and Politser (1980), Rapaport (1970); Organizational Development: French and Bell (1973) and Transformation of Educational Organisation and Practices: Corey (1953), Elliot (1978), Kemmis (1991).

Lewin was full of optimism and trust in the efficacy of action research as a tool of change in institutional life. My very limited experience in work in the Neo-natal Unit makes me wonder if he did not underplay the resistance to change that has to do with unconscious anxieties that is highlighted in the work of Bion.

The work of other researchers; Some of Bowlby's contributions.

Bowlby, more than any other psycho-analyst influenced social policy in the areas of care for children in institutions and of policy towards visiting children in hospital.
From early on he was very interested in the environmental impact on the psychological development of the child.

His work in a maladjusted school and in a child guidance clinic was the background to his papers on attachment. He showed that a child's attachment to its parents is made more difficult by the psychological difficulties of parents. Further children develop similar difficulties to those of their parents and the parents have enormous problems in tolerating this. One case he wrote about was that of a mother who could not tolerate sibling rivalry in her child and who was herself very jealous of her sister (1977).

His famous paper Forty four juvenile thieves (1944) linked lack of caring input into the child's life with the creation of a juvenile criminal who is uncaring for others.

The work on the impact of separation on the personality development of young children that was done by Bowlby, the Robertsons and Ainsworth who co-founded the Attachment Theory, is the most relevant to my work in the hospital.

The very moving film "A two year old goes to hospital" made by the Robertsons and the research work Bowlby did later for the World Health Organisation transformed policy towards visiting ill children in hospitals (1951).

Today it is difficult to think about a pre-Bowlby children's ward.

In one of the meetings of the Journal Club on the Neonatal Unit (discussed in Chapter 3) we were listening to
the director of the service talking about her 40 years as a nurse. She recalled that as a child she contracted an infectious disease. She was placed in an isolation ward, and her parents were allowed to come to the door of the ward and look at her from there once a month. Miss D stayed in hospital for a few months and she thought that that experience was one of the reasons she decided to become a nurse when she grew up.

The change Bowlby's work brought to hospitals was enormous and is reflected in the official policy on the Unit which is to try and make parents do as much as possible, as soon as possible for their babies. Babies of 29 weeks gestation or less are breast fed if they are well enough. They are brought out of the incubator even earlier for a cuddle and "kangaroo care" if they are stable. Parents are addressed by the posters on the walls telling them that the doctors and nurses of the unit know that only they the parents can love and give a sense of warmth and continuity to their infants. They are encouraged to stay as long as the can and talk, sing, stroke, clean and feed their infants (discussed in Chapters 5 and 6).

The work on Open System Theory (Trist and Bamforth, 1960) and on the Socio-Technical System (Rice, 1963) interested me when I thought about the complex interactions on the Unit. The obvious conflict between two systems is the conflict between what is medically necessary for a baby to survive, and what is necessary for a mother to maintain her confidence in her maternal role. Women must feel defeated and devalued as mothers, in the face of all the machines that are essential, and take over from them in sustaining the lives of their babies. There is tension all the time between the two systems: there is internal tension and conflict, between the mother feeling devalued
and feeling paranoid about what is being done to her infant, and feeling grateful to the team that save her baby's life.

I tried to introduce a way of working and thinking in which the medical system adjusts to the needs of the mother-infant closeness, thus minimising the damage to the mother's confidence in her role as a mother, in order that she can tolerate more easily the medical input into her baby's life.

Trist’s work in the mining industry and Rice’s work in India describe changes introduced into systems to take into account the psychological needs of the people involved. Chapter 3 describes the changes that I introduced in an attempt to facilitate a similar effect.

The Tavistock Institute of Human Relations was born after Dunkirk in 1940 when a team of psychiatrists, clinical and social psychologists, sociologists and anthropologists was established in London. The team played an important role in various military issues such as Officer selection, morale in Officer Cadet training, Officer selection boards, and civil resettlement units for repatriated prisoners of war. This team formed the core of what was to become the Tavistock Institute of Human Relations (Trist "The social engagement of Social science").

They brought to the field of group and organisation study original complementary ideas. Lewin's ideas on action research, group dynamics and field theory, life space and Training groups, proved to be central to the development of group research and the Tavistock Conferences.
Bion's work on groups was the other major influence in the Tavistock at that time.

An important and widely used theory was that of the Open System derived from von Bertalanffy's work (1950) used by Lewin and expanded by Trist and Bamforth's in their work on the Socio-Technical System in the coal mining industry. This put forward ideas that were in contrast to classical organisation theory: whereby the human element is subordinated to the technological needs of the organisation. The concept of the Socio-Technical System was beautifully used in the work of Rice (1963), Trist et al (1963) and Emery and Trist (1960); the latter showing the possibilities of enhancing productivity by adopting one system (the Techno-Economic) to the needs and traditions of the workers who form the Psycho-Social System.

The Open System theory enabled Miller to study the relation between the social and technical, and helped him to conceptualise the relationship between the individual and the group (Miller, 1993).

The Open System in the organisation

A Neo-natal Unit is a highly technical place. Around every incubator there are electrical devices monitoring heart beat, oxygen intake and other gases; a nasal tube, various charts, ventilators and so on. The smaller and iller the baby, the more machines there are around his incubator. Around all this equipment there are very anxious parents, and sometimes grandparents. The Nurse needs great skills to deal with the infant in her care, the machines, the very worried families and with all the other professionals who come in to do their work
including Doctors, Physiotherapists and many others. The Nurse has to deal with the mechanical aspects of her work as well as the human side, her patient and his worried family, her colleagues and her superiors.

I spent some time looking at the shift change on the Unit, when one shift hands over responsibility to the next shift. I thought about the work of Trist and Bamforth in relation to this.

In a number of studies on new working conditions in the nationalized coal industry, Trist and Bamforth made some important observations. In papers from 1951 onwards they looked at the Socio-Technical Systems. The introduction of new machinery involved drastic change in the social and psychological structure of miners at work. The old tradition was that of two miners who, with one or two assistants who were self-chosen, made their own contract with Management regarding the amount of coal to be hewn and wages to be paid. Each pair was multi-skilled and multi-tasked, responsible for the entire cycle of operations. This little group set its own target. There was no organisation structure between the small groups and the colliery, they functioned with what the authors termed "responsible autonomy".

New systems and new mechanisation of conveyer belts and coal cutters made the long wall system (ie the working of a single coal face of 200 yards) possible. This new technique had major implications for the way in which the work and workers were organised: now the work was organised in three shifts and each shift was responsible for a single task: cutting, ripping or filling. There were seven different roles and a face worker was trained in one role only. The three shifts never met; no social
integration could be achieved between the different shifts. The writers illustrate the problems that faced the third shift. There were 20 miners each working on a ten yard stretch, however there was little contact between them, and none with cutters who had cut the coal on the previous shift and on whom they were completely dependent. The writers maintained that these were the conditions that caused psycho-somatic and neurotic disorders. Trist and Bamforth concluded: "That a qualitative change will have to be introduced in the general character of the method of the long wall system so that a social as well as technological whole new system can come into existence"(P37).

Their conclusions, which are of importance to the management of change, are that the new technological factors regarding machinery has implications for the new methods of working, the organisation of the workers, their relation to the Management, and to each other. Their concept of the socio-technical system implies that the optimum level of technological usage is one that maintains a balance between the technology and the people working in the system.

The Neo-natal Unit was used to a change of shifts that was a very cold and matter of fact process. It used to concern itself only with facts and figures, for example: "His heart rate was X, his oxygen intake was Y". Facts that were written down and could be picked up from the charts were reported.

With the changes in the ethos came some changes in the shift changeover. Whilst the technical part remained very important, a human factor was introduced: a Nurse would add "his mother came in and was very upset... she said...
and I said..." or about the baby, "He was not so good when I took blood... seemed tired, took so much milk and fell asleep so I think he will wake up and need to be fed early". While the structure of the work on the Unit has not been changed, the sense that the technical aspect has to be in the service of the human factor has grown.

Trist, in his paper "The assumption of ordinariness as a denial mechanism" follows the introduction of new technology and shows its failure. Both miners and managers employ the mechanism of denial, denying the facts that the tasks are new and that time is needed to learn and master new skills and new techniques. An assumption of ordinariness denied the difficulties, the groups were divided into different basic assumption groups and learning from their experience became impossible. Reality was subsequently introduced by the good management of the Area General Manager.

Trist states that the obstacles to solving this problem were anchored in the fact that "the prevailing norms did not provide any precedent, or tool kit for analysing factors in the socio-psychological system in a way which would have broken down the assumption of ordinariness in the starting situation, and avoided the consequent tensions and loss of production. In other words the denial of the total novelty of the situation is introduced as an attempt to deal with the worries attached to the reality of a new situation and the need to learn from experience" (ibid P492).

Trist and Emery link this to the Open System for a number of reasons:
1. Socio-technical systems form by processes of internal elaboration.

2. They manage to achieve a steady state while doing work; although there is a continuous throughput, the enterprise as a whole remains constant.

The system must be able to respond, reactively and proactively, to external market forces. "It follows that the Open System concept must be referred to the socio-technical system, not simply to the social system of an enterprise" (Trist and Emery 1969).

I tried to look at the Nurse's task of looking after the baby and her sources of information as an Open System. She needs to have a balanced approach to the baby and the machines that are around him. The Nurse has to get information from the patient and the machines. When the Unit does not function well the focus is on the machines. I often heard from new Neo-natal students and new Doctors how difficult it is to take blood from such tiny babies, and that they, the new members of staff, felt that there was an expectation that they would be able to do it straight away. They told me how worried they were about all the electrical machines they had to know how to work, and how worrying the thought of the machine not working was. It is only in the last few years that an engineer has been attached to the Unit to maintain the electrical "works". It used to be presumed that Nurses could and should be able to deal with all this.

I have no doubt that the denial that Trist describes was used a great deal in the Unit.
Boundaries

An important concept linked to Open System thinking is that of boundaries. According to Miller (1994) boundaries are the areas where the relationship between a system and the outside world takes place. The inner boundary is where the internal sub-systems interact. "Thus the boundary region may be seen as the location of those roles and activities which are concerned with mediating relations between outside and inside. For example, the leadership exercised in this region can protect the internal sub-system from the disruption of fluctuating demands from outside, but it also has to promote those internal changes that will enable the enterprise to be adoptive and indeed proactive in relation to the environment" (ibid).

I thought about the Neo-natal Unit as having a boundary that divided it from the other units which it has a close relationship with. The babies are the patients of the Unit whilst the mothers can be patients of the Obstetric teams. Obstetric difficulties were often raised in the Parents Group meetings. We usually listened and one of the Sisters (as a Midwife) would sometimes be able to help, explaining the facts or referring the issue to an Obstetrics ward Sister.

It seems to me that a boundary also separates the people who belong to the inside and the people who are on the outside. I often hear comments from the parents about the differences between the culture of the Neo-natal Unit and that of the Maternity Ward.

There is even a physical difference between these two wards. The Neo-natal Unit includes a long corridor by which it is approached. The corridor is full of murals and
plants and it houses the toy corner for the siblings of babies in the Unit. This is in contrast to the corridor outside the Unit which is bare. It is almost as if you feel you have crossed the border from one country into another one. The "language" spoken is somewhat different: "life style" is different, the level of anxiety is higher, babies stay a lot longer on the Unit than in Maternity Wards.

**Primary task**

The "Primary Task" concept developed by Rice (1969), was very useful to me when thinking about the work in the Unit. I thought that the task at the assessment stage was seen as that of saving the lives of the babies. However while the team in a "work group" identification actually saves lives, in a manic state of a basic assumption group it has the arrogance of a divine being regarding itself as a "saviour" while failing to do its real job. Over a period of time I realised that the task needed to be both enlarged and altered: to move from the paranoid to a more reality-based task, linked more to the depressive position. (The example put forward is in Chapter 4: "The move from cynical despair to the ability to mourn" looks at this aspect of change in the team's perception of its task.)

I thought that the task of this project was to help the team to redefine its task and enlarge its area of work. It has a duty to the baby and also to its family if it is to help the baby survive and grow: "attached" to the premature baby are the premature parents with their own difficulties. I think that the work with the parents, with the support of the staff, is evidence that the primary
task is now viewed differently from the way it was seen originally.

Rice worked as a consultant to a weaving company in India when automatic looms were introduced and many problems occurred. Rice was approached by the management and did some action research which is reported in his book (Rice 1958).

"Primary Task" is a concept based on Bion's work on groups. Bion stated that the group function is to do some work. It can do this if it is functioning as a work group and is not overwhelmed by basic assumption phantasies or anxieties.

Rice states: "Each system or sub-system has, however, at any given time one task which may be defined as its primary task: the task which it is created to perform... What is the primary task and how well it is performed is the most important way any organisation should judge itself" (Ibid P32).

For Rice the performance of the primary task is supported by powerful social and psychological forces which ensure that considerable capacity for co-operation is evoked among the members of the organisation created to perform it. Primary task is the task the group must perform in order to survive. "As a direct corollary, the effective performance of a primary task can be an important source of satisfaction for those engaged upon it". Further he stated that the task has to allow for people who are engaged on performing it to feel it to be a whole task, to control their activities and to be able to form satisfactory relationships" (ibid P33).
Another important discovery was that an Open System can achieve an effective state from a choice of organisational structures. The technological and social structures are working most effectively when they harmonise with a Socio-Technical System. Change in one will imply a change in the other.

The group structure that was right for the Indian company was based on the old Indian tradition of small village communities. Rice thought that technology should not dictate the social structure. The assumption, often unconscious, that technology must completely determine social organisation, need not go unchallenged (Rice 1958, P253).

Summary

Psychoanalysis has a unique insight to offer to understanding issues in the field of man's relation to his outside world, man's relationship to others e.g. both in the family and in groups. Freud explored the processes that bind man to his artificial group. Klein explored the life of a young infant in the adult in her writings on the paranoid-schizoid and the depressive position. Bion explored the group that is in touch with reality i.e. the "work group" and the group that is cut off from reality by virtue of being overwhelmed by psychotic anxieties and phantasies that are enacted in the group life. Lewin explored in a controlled way in the field, what happens to production if conditions are changed. Menzies Lyth has shown what takes place if anxieties flood into a social structure and rigidify it.

These thinkers produced change in society. Lewin made it possible to think about social phenomena as a scientific
area of study. Following on from his work people have tried to understand social rules and social events. These original thinkers produced the ideas that fed into my theoretical framework and helped to develop my thinking as this project developed.

1.5 Psychological Neo-natal investigations.

Background:

Evolution of Special Care baby units

When Freud, Klein and Winnicott write about the "baby" or the "mother" they are referring to the full-term baby and to the full-term mother. It is surprising that whilst the care of premature babies has a long history, psychoanalytic literature has, until very recently (Pointelli 1985, Negri 1994), to the best of my knowledge not mentioned this topic.

The consequences that prematurity have for the baby, its parents and the interaction that ensues seem to me to be an area that has not been explored very much by psychoanalysts. How it affects the unfolding development of both the baby and the parents is an area that I think needs to be explored in depth. Early object relation looked at in psychological infant research shows the infant to be aware of self-organising processes and having a sense of an unfolding self (Stern 1985). However the processes that take place at the start of a premature baby's life need a lot more investigation.
Care for pre-term babies has a long history and Brimblecombe (1983) sets out to show that most of the modern interventions have their origins in ideas about care for full-term sick babies and preterm babies in the writings of physicians, philosophers and teachers that started at least 3000 years ago. There is archaeological and anthropological evidence that these were matters of concern in even earlier times.

Early work on infants includes positive pressure ventilation by mouth-to-mouth respiration recommended by Bagellardo in 1472 and the use of tracheotomy for older children and adults described by Paracelsus (1493-1541). Laryngeal intubation for the newborn was described by Smellei (1752), and positive pressure ventilation was referred to by Petit in 1770. Oxygen, discovered in 1771, was applied to the newborn by Campbell and Poulton. There are records of attempts to maintain body temperature of pre-term babies, for example in 1760 peasants of Westphalia and Silesia placed weakly newborn babies in jars of feathers.

In 1878 Tarnier introduced incubators into the Paris Maternity Hospital, an idea copied from Martin who invented a warm chamber for raising poultry. Tarnier was able to show that the survival rate was much improved through this treatment. Automatic temperature control was added by Hearson in Berlin, and Differ added a mechanism to control ventilation and humidity.

Tarnier and his pupil Budin, influenced by Pasteur's work on infection introduced two new methods into their management of pre-term infants: (i) isolation from
infection and (ii) special attention to hygiene in the feeding and care of the infants.

By 1895 the first Special Care unit was established by Budin in Porte Royal Hospital in Paris, with the help of his chief Midwife, Madame Henri. Budin encouraged his pupil, Couney to show the Parisian methods of neo-natal care at international exhibitions. The first of these was in Berlin in 1896. He showed 6 incubators and was warmly supported by the Empress Augusta Victoria, the protectress of Berlin's Charity Hospital. "Several batches of pre-term infants who were otherwise considered to have had little chance of survival were successfully reared during the course of the exhibition". Couney showed the incubators in London in 1897 and again at the World Fair in the Agricultural Hall, Islington. The Lancet reported the event but for many years the focus of Obstetricians, who were responsible for the care of mothers and newborn infants, centred on maternal mortality rather than on that of the infant.

Progress came slowly. Units were established in the U.S.A. and Europe. One of the earliest was created in 1914 in Chicago at the Michael Rees Hospital where progressive improvements were made including the use of portable incubators. (Hess, 1922). The U.K. trailed behind Europe and the U.S.A.; Brimblecombe suggests that this was the case until Paediatricians became more involved in neo-natal care (ibid P36). The first Unit in England was established by Mary Crosse in Birmingham in 1931. She led the way for the next 15 years but there was no increase in this facility until the introduction of the National Health Service in 1948.
In 1961 the Department of Health published "The prevention of prematurity and the care of premature infants" which recommended the provision of special care baby units in all large and medium sized maternity hospitals (HMSO 1961) but this was only endorsed as national policy in 1971 by the DHSS, with the recommendation that regional and sub-regional intensive neo-natal units should be established (HMSO 1971). Summarising: The knowledge that pre-term babies grow to be somewhat handicapped with delayed cognitive and language performance has been available now for 30 years (Drillien 1964). While some infants develop impairments ranging from the most severe to the mildest, others suffer no adverse effects from premature birth (Werner and Smith, 1977).

More and more VLBW babies survive without major neurological impairments such as cerebral palsy, blindness and hearing loss. The rate of major impairment in VLBW survivors has been reduced from a level of 20%-30% in the early 1970s (Stewart et al 1981) to 10%-15% in more recent reports (Brothwood et al 1986, Costello et al 1988). However, long term medical complications including chronic lung disease, infections and visual impairment such as delayed visual development are markedly more frequent in VLBW infants (Fielder et al 1986).

As improvements in neo-natal care reduce the numbers of severe neurological handicaps, the focus on the more subtle disorders takes centre stage in the literature (Crnic et al 1983).

**Background to Interventions**

Ideas that were the theoretical underpinning of a lot of early research were mainly attempts to compensate sensory
deprivations (introducing a heartbeat recording into the incubators, and other sounds that seemed to pacify the infant) or attachment deprivations. (The works of Klaus and Kennell (1983), Brazelton et al (1975) stress the sensory discriminatory skills present already in the uterus.)

At the same time some detailed observations were made in trying to further understand the functioning of the pre-term infant (Als, Brazelton 1979) which could have a negative effect on the care given. In the introduction to his famous book "Neo-natal Behavioural Assessment Scale" (1984) Brazelton states "the newborn's marvellous capacity to control levels of stimulation by the use of state (from sleep to alertness) impressed us with each well-organized infant". However Brazelton points out that an infant who has too low a threshold for the intake of stimuli (hypersensitivity) or has too disorganized a response to stimuli, might be at the mercy of his or her environment. Learning to handle internal psycho-physiological reactions and to control motor over-reactions might be a long and costly task for such a disorganized baby. This infant would be difficult for his or her caretaker as well, and might be at risk from neglect or abuse from an intolerant social environment. Brazelton then provides a scale to help predict the possibilities and thus help the parents and professionals in the caring of the premature baby.

Some psychoanalytic thinking on early object relation

Psychoanalytic thinking of the very primitive needs of the full-term baby are in Klein's work on the early projection and introjection linked to the life and death instincts interacting in normal development (1952). In the paper
"The importance of symbol formation" (1930) she put forward the view that the difficulties of a normal development can be a result of being overwhelmed by sadism.

The difficulty of introjecting and projecting as a cause for psychotic illness is developed in Tustins's work on autistic children who, according to her are trapped in a sensory sensation dominated world alone (1981). Winnicott and Bick wrote about traumatic early loss leading to profound difficulties in developing normal object relation. Bick developed the concept of the infant with no proper containment as going into "a free fall into space" developing a second skin (Bick 1967) or "a false self" (Winnicott, 1958).

For Winnicott, Bick and Tustin the concept of an early trauma is central to understanding later pathology in psychosis and autism. Tustin, like Mahler, writes about psychological birth when the infant moves, develops and gets away from a sensory dominated world to one where he has some ability to distinguish between "me and not me" state of affairs. The infant needs, according to Mahler and Tustin, some experience of continuity of being at one with its object: a disruption may lead to a trauma and possible serious pathological development.

Tustin's theory of the road to psychosis via the early trauma of the physical and emotional rupture of the containing environment, leaves me wondering why the majority of premature infants who grow up do not become autistic. Here in the Neo-natal Unit, we see day-in and day-out major sudden dramatic disruption to the illusion
of "going on being" of the infant and his object being at one.

My difficulty with Tustin's theory is that it seems to be too global. I see a great number of babies who were born prematurely, their togetherness with their object suddenly disrupted for some time, but who do not develop autism or serious developmental difficulties. I should like to know how was the trauma absorbed by some of the infants but not by the others.

Interventions

Subtle developmental deficits of LBW infants have been identified in a variety of domains. Language delay in LBW infants both in comprehension and in expression have been noted (Byers-Brown et al, 1986 1983, 54). A difficulty in motor visual integration is common for the LBW and VLBW infant (Siegal 1983, 1984). VLBW babies were found to have motor problems causing them to be more clumsy children (Marlow 1989). Minde (1984) showed that infants born before 1965 who were LBW had a more than average number of behavioural and emotional problems. Their prolonged hospitalisation and separation from their parents make them more likely to be subjected to abuse, an outcome of bonding failure (Albermand 1979, Humphrey and Lloyd 1979, Ounsted et al 1982). VLBW children do not do as well at school as might be expected according to their abilities. They often need remedial teaching despite having cognitive abilities within the normal range. This is thought to be linked to poor attention span and overactivity, noted in these small children from infancy. (Field et al 1981, Minde et al 1989, Veen et al 1991).
A number of direct observations of mother and LBW infant in the first year of life suggest that mothers are more passive and less affectionate in interaction, or overstimulating. The infants who suffered severe neo-natal illness have repeatedly been observed to be more passive and less socially engaging in interaction (Barnard et al 1984, Field 1977, Jarvis et al 1989, Brachfeld 1980).

It is very interesting to note that the findings were not reproduced in the laboratory with the Ainsworth Stranger Situation. A number of studies did not find more insecure attachment in LBW babies relative to those born at normal weight (Easterbrook 1989, Frodi and Thompson 1985).

A number of general conclusions can be drawn from the findings of outcome studies:

1. A significant minority of LBW infants suffer intellectual and behavioural deficits.

2. Birthweight per se is not a good predictor of motor, cognitive and behavioural development. The severity and chronicity of neo-natal illness are more potent predictors of infant development.

3. Prediction of abnormal outcome in LBW children who had peri- and neo-natal complications is far from perfect, despite better diagnostic techniques for brain lesions. The caretaking environment has a profound effect on the low birth weight infant's long term development (Wolke 1991).
In his paper "Supporting the development of low birthweight infants" Wolke groups interventions under five major theoretical models:

1. Programmes that aim to counteract neo-natal sensory deprivation.

2. Programmes that aim to counteract faulty mother-infant bonding.

3. Programmes that aim to help parents resolve the emotional crises of premature delivery.

4. Programmes that aim to help parents to be more sensitive and responsive to their baby's cues and improve the mother-child interaction.

5. Programmes that aim to compensate infants identified later in the first year as having general or specific developmental or motor problems.

Field (1980) looked at the outcome and commented how difficult it is to analyse the results. The different programmes vary in size of sample, length of the trial, follow-up periods and outcome measures used.

Overall most the studies that provided extra stimulations found positive short term effects in respect to improvement of weight gain, start of oral feeding, behavioural organization namely increased sleeping, reduction of crying and apnoea.

It seemed that not all pre-term babies benefited from extra sensory stimulation. It could be that any type of stimulation works independent of the sensory modality;
Richards suggests that the effects are unspecific. He claimed that the special attention given to the babies by the nurses is the cause of the improvement (Richards 1984). Other workers (Jones 1981, While-Traut and Carrier Goldman 1988) found that some extra stimulation on small newborn infants can have an adverse effect.

Wolke argues (1986, 1987) that these studies show that there is a mismatch in the under- or over-stimulation of the babies and like Als (1986) he argues for an individual programme for each baby. His findings were that the individual care programme that measured every infant's needs of oxygen, light and noise worked well. The infants in the programme were ventilated on average 24 days less than the control group and moved to oral feeding 30 days earlier than the control group. The treatment also resulted in long term gains including significantly higher mental development scores and more reciprocal interaction at nine months. An individual care approach, educating nurses and parents on how to contain and promote the individual infant's behavioural organization, appears to be the most promising approach for direct developmental support of the very sick infant in hospital (Als et al 1986). "Low birth weight and assisted ventilation are two of the three risk conditions associated with the highest cost in neo-natal intensive care and with the most costly physiological and developmental outcomes. Reducing these financial and developmental costs should be a priority of medical and nursing care" (ibid). This view is also to be found in Gorski et al (1979). These authors argue for an individual caring approach that takes account of the state of alertness or sleepiness of the infant. Feeding and medical interventions if they are to be effective, should be focussed on alertness time of the baby. Many clinical observations are quoted in this paper.
demonstrating a lessening of apnoea attacks and an increase in weight gain when this principal was adhered to.

Romana Negri in her book "The Newborn in the Intensive Care Unit" (1994) takes a Neuro-psychoanalytic prevention model approach, demonstrating her sensitive individual care for the baby and its parents. Negri argues that the poor outcome of a socially deprived neo-natal baby is linked not to lack of stimulation but to the non-responsive environment which is present in its world. Too much noise and light and lack of direct attention is what these babies are normally exposed to in the Neo-natal Unit and later on in their home situation. "Our finding concerning the negative responses of premature infants to the often overstimulating environment of the special care nursery may apply here. Perhaps in an overstimulating home environment not sensitive to their needs these vulnerable babies are too easily overloaded and must withdraw. The behavioural disorganization of such an infant can set off parental responses that attempt to reorganize him too quickly... The overwhelming parental response stems from caring too much, not too little. With proper direction, they can easily be turned into responses appropriate to the vulnerable infant's particular need" (P 71).

In my view the mismatching of care by the deprived parent may be linked to the parent's anxiety which acts as a choking mechanism of thinking. The emphasis in the work mentioned above is on showing the nurses and parents some very important facts about the ability of the infant to respond to stimuli, as if that by itself would cure the problem. I am sure it can help but what I thought was missing was the recognition of resistance to learning in
the staff and in the parents, and which is based on unconscious anxiety.

Work with parents

Klause and Kennel (1975, 1982) looked at the mother-baby interaction and noticed that mothers exposed for six extra hours to their babies were more attentive and interacted in a more lively way with their babies than the control group that were allowed no extra time with their new born babies.

Current views on attachment and loss owe a great debt to Bowlby's work in this area. His work had enormous influence on the policy on visiting arrangements of hospital childrens' wards in this and many other countries.

His work and that of others e.g. Klause and Kennel, Robertson (1953, 58, 69a, 69b, 67-71) brought enormous improvements in the environment of these wards.

The idea that the facilitation of contact shortly after birth leads to bonding of the mother with the infant, and to more and better caretaking subsequently has proved to be an oversimplification. In his paper, Richards (1985) states that "Bonding is no longer a useful concept... In order to move beyond a notion of the absence of separation as a basis for organising care, we must understand the nature of infants and parents psychological needs. I think it is now clear that the notion of bonding has become a block to this understanding... We need to move on to build a psychology of parenthood based on an appreciation of the full complexities of human behaviour." This view is supported by a number of observations suggesting that
parents felt compelled to handle their small fragile infants even if they intuitively felt that looking was enough.

(In Chapters 5 and 6 I bring some examples of the complicated, acutely ambivalent feelings that mothers have for their premature infants and which influence their relationship to their babies.)

A number of parents support groups have been reported in the literature. These were formed with the view that dealing with the crises in the parents' life would indirectly help their role in parenting (Minde 1984, Crinc, et al 1983, Klause and Kennel 1982). The reports suggest that mothers gained in their sense of competence and more visiting and interactions with the babies were noticed.

Minde felt that the best way to prepare mothers of premature babies both emotionally and practically, for the task of parenting was through the self-help group. His study was influenced by the clinical work of Dumont and Caplan (1974). Minde's opinion was that many parents would more readily accept supportive teaching from peers than from health professionals (Minde et al 1980, 1983).

The meetings of parents where feelings of depression, guilt and fear were shared helped, as it made parents see they were not alone in having these feelings. In analysing the results it is interesting to note that the parents who showed the highest degree of overt psychological and social pathology (e.g. mothers who had a husband in prison, were physically mistreated or showed symptoms of a major psychiatric disorder) had the lowest attendance and attended groups only after 4 to 6 individual sessions
with the group co-ordinator. Another interesting factor is that almost 50% of the families who took part had lost one to seven babies during various pregnancies (Minde, Behavioral Ped, 96, 5, 933-940). The mothers in the experiment visited more and interacted more with their infants.

Educating parents about what babies can and cannot do or tolerate was a way that provided a better interaction between parents and babies (Als 1982).

A work by Rauh and others (1988) looks at combining intervention in the Unit with help for parents and continuing support at home. It showed the need for longer-term follow up. The differences between treatment and control groups increased over time and were highly significant at 3 and 4 years of age, although the Home Intervention programme had finished 90 days after discharge of the infant from the hospital. The IQ scores of the Intervention group at the age of 4 were identical to the average, the infants who did not receive Intervention were markedly delayed.

Comments

There are more and more babies who survive "unfinished" pregnancies, and more will survive with technological developments in the field. New discoveries bring with them new hopes and new difficulties. We are confronted with babies who start their lives in a way different to that of the infants that the great psychoanalysts wrote about. Interesting and important work has and is being done in this field of psychological neo-natology.
I find the results of Als' work in Boston, Negri's work in Italy and Richards in Cambridge very convincing. There is evidence that intervention brings significant results for example in preventing further difficulties for the infant and its family and minimising further financial cost for the community.

In her important work "Born too Soon" Jane Griffin from the Office of Health Economics sets out the financial cost of the education of the pre-term baby:

"A recent American study (Chakinid and Cormen, 1991, 1987) found that low birthweight survivors were likely to experience serious health problems in infancy and beyond, and found that they were more likely to experience preschool developmental delays. They also discovered that children who weighed less than 2500g were 50% more likely to be involved in some type of special education than children of normal birthweight. The authors calculated that in the U.S this results in an increased cost of special education of $370 million (1989-90) per year due to low birthweight. Whilst the provision of services in the US and the UK are not strictly comparable, if these costs were to be repeated in the UK and adjusted for population size, the cost in the UK for special education for low birthweight children would be in the region of £150 million per annum (1989-90)" (P46).

It makes sense to take measures for the prevention of premature birth and that as much help as possible as soon as possible is offered to the families.

In this vast field of research work, I did not find any references to the psycho-analytic work influenced by Bion, Jaques and Menzies Lyth that take on board resistance to
change as a defence against psychotic anxieties. This might be one reason why the research findings were not and are not taken up and adopted by the clinicians as soon as, or as whole heartedly as they might. I also wonder if the same argument applies to the work with the deprived parents who over stimulate their premature babies (Negri 1994).

It seems that the unconscious anxieties of producing less-than-perfect infants may drive parents to be unattentive or over stimulating. Most of the work reported is by researchers who find out data and publish and go away. Brimblecombe (1983) shows how insight that was available to the ancient Greeks about the importance of for example breast feeding, gets forgotten and needs to be re-discovered. If research work in this field is to have an impact on clinical practice, it needs to be underpinned and supported. It seems obvious, it makes sense, to try and know the baby and tailor the intervention to the baby's state, as shown in Als' and Brazelton's work. I wondered if the unit in Boston had carried on the treatment as reported in Als' good paper(1986), after the research had been finished, and the papers were published. She does not refer to the long term outlook in her paper. I did not find any comments on the likelihood or otherwise of this good pattern of work continuing. Most studies do not consider the aspect of long term co-operation of the team, or the lack of co-operation.

The staff on the units are mentioned, but not a lot of thinking was given to their negative or positive contributions to the work, the research or to their resistance.
I want to relate an example on this issue of forgetting knowledge: in my Unit there was a clinical seminar every Friday, and one week the subject was "Pain in the neonate". We were looking at a neurological paper bringing evidence of, and measuring pain in the foetus. I said that I thought that the babies suffer when painful things are done to them, such as blood being taken from their heels. A Sister said: "We used to use some cream to give local anaesthetics but we stopped and I do not remember why." No one in the room could say why. The procedure was good, it made sense and it was dropped. After the seminar it was picked up again only, I assume to be perhaps dropped again and rediscovered.

Good ideas need careful looking after and monitoring for a very long time or else they get dropped, lost or misplaced. Good ideas need to be re-discovered and relearned by the team (Lewin, Action Research, 1947, 1952). I wonder if the thinking caring "ego functioning" of a team in such a unit gets attacked and abused and, unless it is regularly cared for, will not develop and take proper advantage of the useful research done. Is it in a state of unconscious identification with the damaged babies that the staff are permanently busy with?

It seems that the authors of research work have a great belief that knowledge would help. My experience makes me feel that it needs careful support for a very long time. I suggest that the integrative approach of working with the staff, the babies and the parents, in the Unit and at home became possible when resistance and unconscious anxieties are taken on as a part of the emotinal landscape of a neo-natal unit. Thus an atmosphere of learning is supported in the unit, as an on-going part of life experience. I think that the lessening of the omnipotence
as a defence, the struggle of linking to reality is an on-going process.

It cannot be safely assumed that learning, even of procedure of how to treat pain, will endure. It seems to me that the trauma of prematurity and its impacts on parents, babies and staff is not researched in its totality. The interaction and the connection between the experience of the babies, the parents, and the staff and their ability to think is not linked. In other words the powerful projections and introjections that everyone is exposed to in such a "charged" place need to be unpicked, made conscious, and available for thinking and change. An attempt to do this is looked at below.
CHAPTER TWO. METHODOLOGY, THE PRACTICE.

2.1 The first phase, Assessment

Introduction:

This project was conducted as a psycho-analytical action research project. As such, psychoanalytical tools or concepts were used. There was an aim but no idea of how to achieve it. As the project developed its aim got modified, and in turn gave rise to new areas of study. As this was not a psycho-analysis of a patient, nor the work of an outside consultant, some new thoughts and actions were needed.

There were three phases in the project each needing somewhat different methodologies; these are looked at in the following sections in this chapter. By far the biggest effort in finding the right tools for the work occurred in the second phase of the project. This dealt with the problem of how to change the culture of the Unit from that found during the assessment phase. The methodology of the second phase will therefore be looked at in somewhat greater detail.

The Methodology in finding a working Hypothesis

A sense in the management of the service that the Neonatal Unit was not functioning as it should, was the reason that a letter asking for help was sent to the Psychiatric Division. After a while, it was turned down by a number of agencies. I responded for a number of reasons that are looked at later on.
The presenting problem was clear, what caused it was not. The start of this project was not to do research as such, but to try and solve a clinical problem. The Manager of Midwifery Services wrote asking for help, she was worried about the staff in the Neo-natal Unit that she had started a few years before. When I saw her, she talked about her concerns: damage to the equipment which she felt was deliberately done, and was putting babies lives at risk. She also worried about one nurse who she thought needed some psychological help. We agreed at that meeting that some exploration would take place and I was invited to come back and share with the Manager and her deputy what I found. I made it clear at the start that I could not look after the one nurse and that I thought she might be acting because of her own pathology or the pathology of the team. Early on in the exploratory phase of this project this member of staff was moved to another ward.

Observations

I made some observations of mother/baby and mother/nurse/baby interaction in the intensive care rooms which I recorded later outside the unit. I used my feelings and thinking in the recordings. An air of brisk efficiency and forced gaiety was the usual sense I got as I went in, as if every one knew what, how and where and when things had to be dealt with. Not only the nurses were briskly busy also the mothers seem to be in a rush to somewhere else. I thought that I was the only lost person, confused, worried and out of place. It was a worrying place, full of machines and charts and tiny babies fighting for life. It took a while for me to become less scared and try to understand why I felt what I felt and thought what I thought; how the Unit affecting me and other people.
After a while I thought I knew what might be at the root of this phenomenon of the "the nurses running with their aprons flapping". I knew that I felt very much like them in wanting to flee a very painful and scaring world.

The implications of observation for the researcher

Using my feelings and thoughts; emphatically allowing the data to impinge on me I thought I understood the wish to flee with "my aprons flapping". It seemed that the "border point" from which I observed and collected data was a somewhat exposed position, it was not possible to be impartial all the time. I could only try and acknowledge my feelings and use them to the best of my ability.

It is all too easy to be overwhelmingly identified with the emotional world of the parents, babies, or staff. As I became "hardened" I was able to try and and use both common sense and feelings.

Conclusions

As a result of the first phase I concluded that the team was operating on a part object level, suffering from a high degree of cynical despair, perhaps identifying with the dying or "murdered" baby: I report on in detail in the next chapter. It seemed that separateness and the ability to mourn was very limited. Instead of symbolization a process named by Segal "symbolic equation" takes place: "Parts of the ego and internal objects are projected into an object and identified with it. The differentiation between the self and the object is obscured. Then, since part of the ego is confused with the object, the symbol - which is a creation and a function of the ego - becomes, in
turn, confused with the object which is symbolized" (Segal 1981).

I thought that the Unit if it were a person could be described as having a break down. Human beings were devalued to a dangerously low level. I thought that I needed to intervene, first of all by action looked at in detail below.

This is one of the important differences between working as an analyst and working as a consultant to the Unit; I had to "do" and so I did. I tried to create some facts on the Unit. It seemed to me that what was needed first in order to try and bring change in the culture of the Unit was a non-threatening situation of people coming together. Basically there was an urgent need for people to learn to talk to each other, a time and place where thinking could take place was required. This brought me to the second phase of the work where some action was taken. I created a few interventions with the aim of starting to change the ethos of the Unit.

With the support of the Nursing officer and the Consultant I started a Journal Club, a toy corner and a campaign to try to reach the parents of the babies and make them aware how important the staff think their input into the life of their babies is. I could not wait for the change to come from the fragmented unthinking team. The set-up for this work had to be established, it needed to be supported and suggested by me as the outraged ego of the Unit. What I saw and heard moved me or drove me into action, the account of which is reported in some detail in Chapter 3.
Some of the deficiencies of the setting

Below I discuss briefly the need to recognise some fundamental requirements that initially were missing from the setting. I then describe what I did about this. By far the most difficult and most innovative work occurred during this early phase of the project when new concepts were introduced into the life of the Unit.

What was needed and missing in the setting

The work with very weak, ill or dying babies can be so near to unconscious paranoid and persecuting phantasies of damaged or attacked objects, that confusion between internal and external reality can be rife (Segal 1957, The sense of fragmentation, despair and cynical devaluation of people's feelings revealed the paranoid nature of life on the Unit.

When the outside setting does not provide support, it seems the "the ego function" of the team becomes overwhelmed. A sense of despair and a devaluation of life persists; paranoid anxieties are treated as if they are facts rather than a result of anxious perception.

It seemed to me that the Unit urgently needed some input into its life. I thought that its culture of despair had to be confronted and the compulsively repetitive omnipotent denial of pain, manic defences of idealisation and flight from reality needed to be addressed. I felt more or less
compelled to "do something" to relieve the pressure that the data had created in me.

However before I could begin any constructive work, what seemed to be central was to take stock of what was unavailable. It was terribly important to realise what was needed, and was not available at the time.

**Lack of insight**

As a psychoanalyst I have some assumptions that I almost take for granted in my work: that if someone wants to come to see me he may among other reasons want to use my skills for his benefit. He is thinking of becoming a "patient" because of some pain or worry, etc. So even before a first meeting between an analyst and a future patient, a phantasy of a meeting and its usefulness exists in the minds of both the analyst and the future patient.

This was not the case in the work with the team. "The pathology" or "the patient", in this case the ill part of the staff, seemed to be free of any awareness of disturbance. The awareness was located in the Manager of the service. It seemed to me that the people who worked in the place were splitting or projecting their pain or insight into the Manager so as not to be overwhelmed.

**Denial**

In his paper "The loss of reality in neurosis and psychosis" (S.E. 19, 1924) Freud states "In neurosis a
piece of reality is avoided by a sort of flight, whereas in psychosis it is remodelled. Or we might say: in psychosis, the initial flight is succeeded by an active phase of remodelling: in neurosis, the initial obedience is succeeded by a deferred attempt at flight. Or again, expressed in yet another way: neurosis does not disavow the reality, it only ignores it. Psychosis disavows it and tries to replace it. We call behaviour normal or healthy if it combines certain features of both reactions: if it disavows the reality as little as does a neurosis, but if it then exerts itself, as does a psychosis, to effect an alteration of that reality."

For Klein, denial is one of the primitive defences against paranoid anxiety and serves to protect the ego via manic denial of psychic reality. In her paper "Psychogenesis of manic-depressive states" she writes, "Freud has stated that mania has for its basis the same contents as melancholia and is, in fact, a way of escape from that state. I would suggest that in mania the ego seeks refuge not only from melancholia but also from a paranoiac condition which it is unable to master....A sense of omnipotence is what first and foremost characterizes mania which is used by denial in the service of the immature ego as a defence against internal persecutors...That which is first of all denied is psychic reality and the ego may then go on to deny a great deal of external reality."(p277).
Miller (1994) shows the mechanism of denial operating at the foundation of the institution and its impact on the inmates and the workers (p.74). In Chapters 5 and 6 I describe some clinical examples of this mechanism in the life of parents and staff on the Neo-natal Unit.

Lack of any setting for work

Comparing for a moment my working environment as a psychoanalyst to that on the Unit I note some important differences. Built into the analytic setting are conventions and a practical concrete framework. There is a place, a consulting room in which patient and analyst can work, listen, think and talk to each other. There is an agreed time to meet for the agreed purpose. There is a theoretical framework underlining the analytic investigation, and a language that is fed by analytic ideas and gives substance to them in the analytic work.

I had to find a way to create a suitable setting for the "novel" work with the team I wanted to do. I had to establish a time and a place, to locate the "patient", to find a way to listen and understand and then talk in an acceptable and meaningful way.

It was also necessary to get rid of ideas which I carried from another setting that were of no use in a Neo-natal Unit.
I feel that the process of taking stock of the "negative assets" i.e. what was not available in the setting and what was not transferable from the analytic setting, needs to be emphasised.

It seems that some "mental luggage" has to be left behind. I also think that what might be right and useful for the Neo-natal Unit might not suit another setting.

The lack of containment:

The whole issue can be viewed as a lack of any containing situation (Klein 1946, Bion 1967, Rosenfeld 1952, Jaques 1953, 1955). According to Jaques, individuals use social institutions in order to support their own psychic defences, thus creating what he called "the social defence system", wherein the institution absorbs the individual's anxieties and defence system. In this way an institution develops a common unconscious that controls the way it discharges its tasks. A core factor in that common unconscious is the individual anxiety which is a major factor that stands in the way of institutional change.

Following Jaques' ideas in his important paper "Social systems as defence against persecutory and depressive anxiety" I thought that the lack of containment in the Unit was a measure of the degree of disturbance that could not be held in the common defensive system. A very interesting area to consider is when and why does an
institution's defensive system collapses. At the early phase of the work all I knew was that some break had taken place and needed attention. Towards the end of the project I had some ideas about "emotional hurricanes" that can sweep a for a while into mania. At this stage I felt that the right way to tackle the problem was first to try and build a setting for work.

Summary

Moving towards building a setting for work, I tried to look at what was needed but was not available in the Unit. My ordinary psychoanalytic expectations had to be recognised and set aside. It seemed that a setting had to be found that was right for work with the staff on the Unit. A time, a space, a format, and a language had to be found that fitted the needs of the team on the Unit.
2.2. The second phase, Intervention.

Introduction

Initially there was no setting in which people who worked on the Unit could sit together learn, or share ideas or experiences. They did not have a room and a time that was meant for staff to come together. Equally there was no "mental" room or time for such an activity. These concepts seemed to be foreign to the culture of the Unit.

This section is about the actions I took in order to change the culture by providing some new facts in the life of the Unit.

Anna Dartington (1994) puts the problem in modern nursing like this "Contemporary nursing is dogged by a negative expectation that nurse should not think. By thinking, I do not mean remembering whether Mr. Jones is prescribed one sleeping tablet or two, but the processes of reflection about one's work, its efficacy, and significance: registering what one observes of the patient's emotional state, the capacity to be informed by one's imagination and intuition, the opportunity to criticize constructively and to influence the working environment. This is not to say that nurses do not think, but that it is an effort of will to make the space for reflection in a working life dominated by necessity, tradition and obedience. What is usually absent is the opportunity to ask the question why? of someone in authority, someone who is not surprised by the question, who is interested in the answer, and who can engage in a spirit of mutual enquiry." (p 101).
In the following I describe the actions I took to bring about concrete changes and the subsequent changes in attitude that took place.

To start with I had to clarify what was missing in the relation between the people working on the Unit. I had a notion that a sense of a team was not present on the Unit.

What is a team?

Some time after I started to work in the Unit, I was standing in the corridor with the nursing officer when there was an emergency in the room next to us. Mrs. Saunders the Nursing Officer, looked at the staff working and said to me with some pleasure "You know, now we work like a football team, look, we do not even have to talk to each other, we know what each other needs and we do it."

Her words implied a degree of empathy and a sharing of goals which, when I started, was not there. In other words at the start of this project the people who worked on the Unit did not behave as if they belonged to an artificial group, as defined by Freud in "Group Psychology and the Analysis of the Ego".

The interesting factor was that in the main the same group of people behaved in this new and satisfying way. The group did not change, it was its way of being and functioning that had undergone a great change.

Another example of the change in the culture of the team occurred when an ex-member of staff who had left the U.K. a while ago came for a visit and I invited some old friends from the Unit for lunch to see her. E said that
she was on duty on that Sunday. I replied "Look you have a lunch break and I live 5 minutes from the hospital it will be so good to have you even for a few minutes." She told me that they are short staffed and that she would not leave the Unit for lunch not even for a few minutes. She will have lunch when she can, because "you never know what might fall on you in the Unit". When I told the others who were able to come about it, it seemed that this was self evident, any Sister would behave like this. The loyalty, and dedication that have developed are taken for granted. It is a fact that the Unit depends on this phenomenon of dedication. People do more than they are paid for, usually not leaving at the end of their shifts but only when they have completed their job. There is always a shortage of staff and people take on what there is and do it. The Unit has been running like this for a number of years. As Kishon a famous Hungarian Jewish humorist wrote once about the state of Israel "The Jewish state does not only pray for miracles, its very existence depends on them happening, they are taken for granted."

The Unit has an establishment of 30 nurses but has been working with 25. At the early stage of my work this phenomenon was absent. What I mean is that every nurse seemed to be a good nurse but there was no sense of a team pulling together. I shall try to show what I did in order to facilitate the development of a sense of belonging to a team.

My definition of a "Team" based on the Nursing Officer's formulation is: a group of people who share empathetically the goals and aspirations of the group.
The Journal Club

As a way of getting people to come together to think and talk about the Unit's work, I thought that a meeting once a month around a paper or a lecture would not feel too threatening. I viewed it as a "peg" on which to hang a psychological experience of sitting together in the same room talking to each other about professional issues.

The idea was discussed and was accepted by the Nursing Officer and the Consultant Paediatrician. We called it the Neo-natal journal /discussion club. It was to meet once a month on a Friday at a time when there was a shift change-over.

I found the speakers and the papers for the first few months, and circulated the timing and topic for the event in the Unit and the Maternity departments.

Location of the meeting

It was suggested that we should go outside the Neo-natal Unit, to the nursing school or to the medical post graduate building. These places had big rooms. I was against this. It seemed right that we should hold the meetings on the Unit. I thought that the meetings could attract more of the Unit staff if they were on the Unit. If a bleep went people could respond and then rejoin the meeting as we were just on the Unit in another room. It was agreed. We used the parents' sitting room on the Unit. It is a medium size room and we were sometimes quite crowded. An informal atmosphere was created. When not enough chairs were available people had to sit on the floor. It was noted with approval when a sister or nursing officer sat on a small chair or on the floor. I wondered
if this was done to show that in this meeting the rigid hierarchical structure was not meant to be adhered to. It was a new experience and a start to new developments.

The change in the position of the Nursing Officer

The real position of the Nursing Officer is that of manager of the unit. Unconsciously she was seen as very powerful, almost a life and death giver in the setting. After many meetings she was intuitively in touch with what I was trying to bring about. Her support of the Journal Club seemed to mean that she was behind the changes. It was seen as evidence that she was in a different position in the Journal Club and was supporting a different culture in the Unit.

Clinically she carried on working with babies, rather than retreating into an office and doing administrative work. She was a very experienced midwife but not very experienced neo-natal nurse. She was open about this and said she was able to rely on other nurses who were more experienced with the new electronic equipment. The mutual dependency was openly discussed and acknowledged. This was very warmly appreciated by the other nurses. It brought with it gradually a sense of a team. The Nursing Officer fought for her nurses working conditions. They responded by being very loyal to her.

They became known outside the Unit as somewhat different. Some visitors and some of the patients started talking about the nurses on the Unit saying for example "nurses in the Unit are hand picked, they are special, unlike the other nurses on maternity." I think the nurses felt looked
after by their Nursing Officer who in turn was supported by her staff.

The new relation was supported by the culture introduced by the Journal Club and the many meetings I had with the Nursing Officer who used to tell me that what I was proposing was in complete contradiction to the way she was trained. She nevertheless accepted it.

Chairing the meetings

I felt that it was right that the Nursing Officer, or later on a Sister, would chair the meetings and welcome speakers, and so on. It was a departure from the tradition where a doctor chairs the meeting.

The nurses are on the Unit all the time, the doctors move between the Unit and the other paediatric wards. When Mrs. S the Nursing Officer was away she appointed another member of the staff to chair the meeting. For Mrs. S it was a new role. She was a very experienced midwife. She was in her early fifties and had thought that she would retire as a sister. In fact she was promoted a few years later and retired as a Regional Manager. She learned very quickly to run a meeting and was used as a role model by two other Nursing Officers that followed her.

It seemed very important not to be felt as a threat to her authority by myself being in charge of this meeting.

My Role

Not only did I suggest some papers or speakers, but the most important thing I did was to ask questions. Not being
medically qualified I felt able to use my medical ignorance. It meant that people had to rethink and reflect on clinical issues that were taken as routine.

One of the cases was that of twins. One was very small and ill and one was big and well. They were both on the Unitas a matter of course. I asked what were the reasons and was told "this is our policy" but I pushed it and wanted to know the merit of the policy, was it good for the babies? the family? the unit?

Being the "mug" I thought was a very useful way to get people to think and explain. Menzies Lyth and Bain both use Bion's writing in "Attention and Interpretation" where he states that to do psychoanalytic work the analyst has to give up desire, memory, and understanding in his work. Menzies Lyth (1986) writes about taking a fresh look at the situation, setting aside habitual ways of looking at things. Bain (1982) writes about the usefulness to the institutional consultant of ignorance or "cultivated ignorance".

As to the question of what symbolically I became in the life of the team, I can only suggest that I was used at times as an object that was pro-thinking and reality and thus strengthening that aspect in the team. I suggest a process of introjection of a "good object" became stronger, slowly the culture began to change. I was often also rejected as a threat or a bore or a stranger. The projections of these powerful feelings make this work lonely, difficult and at times impossible.
Further developments

The Journal Club became a popular event; some people turned up in their off-duty time; relations between the disciplines improved. The Nursing Officer reported that she noted change in the way people reported mistakes. They were more openly acknowledged, less covered up. Staff started having parties on the unit. The new year of a number of religions and promotions were celebrated on the wide corridor on the unit.

Two papers were submitted to a nursing magazine and the Unit and its team started to feel somewhat more united. The Neo-natal Unit became up-graded and took on more difficult cases. I am not suggesting that it was the starting of a Journal Club that did this, but I am suggesting that I provided a model that was acceptable to the lively "good and reparative" aspect of the nurses and doctors personalities thus enabling them to function somewhat better.

Other events

This stage of my project included a number of other events which I started in the Unit including a toy corner for the siblings and big adverts aimed at the parents.

Using an empty cupboard in a corridor of the Unit I brought some used toys my children had outgrown. I asked friends and neighbours for some spare toys. I wanted used toys rather than to collect money and get new toys. I wanted to try and close the gap between parents and staff, between the "them and us" in a concrete way, to spell out that "we too have children, we are not creatures from another planet." It became a popular project, and nurses
brought toys and a grandmother knitted some cloths for the babies.

The Nursing Officer had a daughter who had a friend at art college and she did a mural for us, a nurse in training did a another mural.

Grace was one of the unit's cleaning ladies (before the work was privatised). She kept some plants in her cupboard where her brooms and brushes were kept. I thought that she was looking after the plants not being allowed to look after the babies. She was a very important figure on the Unit, mothers often confided in her, and she was cheerful and reassuring for them. (I often used to look at her on my way to the Unit as a sort of barometer, if she was singing while dusting I felt that there is no terrible case behind the double doors on that day.)

I praised Grace's plants and she put them out in the corridor where they provided a hot-house effect at the entrance of the Unit. The Unit was full of light and warmth so the plants did very well and continue to flourish.

I wanted to get a message of support to the parents whose babies were on the unit. Travelling on the underground and seeing the adverts made me think that if people pay money for adverts maybe they work. I thought maybe I could try and "sell" some psychological messages to the parents, messages from the staff to the parents. The aim was to make parents aware that the staff expect them to be as involved as possible, that they, their love, commitment and continuity is what they can give and we cannot.
The messages were read by new staff as well as new parents and gradually the culture in the unit began to change. I often now see a new mother reading these messages and sometimes it does seem to counter self doubt and a sense of useless inferiority that some parents suffer from after having an ill or premature baby. It was very difficult to get mothers who felt redundant and useless to stay with their babies. They used to go out of the unit leaving the care of their babies to the staff. With the change in culture it was noticed that visiting increased. The unit got a name of a healthy caring unit.

Discussion: Changing the culture

This somewhat detailed section of the second phase of the project is centred around the action I felt I needed to take in order to create the setting for some further work with staff and parents. With it came a new culture that allowed some thinking or the notion that thinking is required. Hand in hand came the notion that people are important, and so are their feelings. Relations between the Nursing Officer and her staff became more trusting, and more reality based. Mistakes were more acknowledged and less hidden. There were many comments about what a change all this was from the traditions of the nurses and their training.

Put in another way, I am suggesting that the defences that were used, seemed to have changed, from the primitive and rigid to the more depressive that enabled some thinking to take place. In Chapter 4 I bring detailed clinical material to show the staff group being able to think and feel under profound emotional pressure.
There are many examples that suggest a shift in the team's way of functioning which in turn suggest that some containment was experienced that enabled this development to take place.

It seemed to me that this phase was essential to the continuity of this project. I am not suggesting that a Journal Club is right for every intervention rather that a period of assessment has to include some thoughts about the right shape and structure of the intervention that will take into account the need of the organization to resist change.

2.3 The third phase: The work of the staff and parents groups

Introduction

A move towards the third phase of this project took place when a sense of some integration was present. There was some evidence of growth; the staff worked more as a team. It implied a degree of empathy and shared goals. This made me move towards the third phase.

The staff group

This is a somewhat more sophisticated event than the journal club. It is a meeting that has no agenda and functions in a mode as near to free association as I can make it. The staff group meets once a fortnight.

We have a time to look at a case or a difficult issue in the life of the unit. Also the newest member of the team is asked to share with the meeting what might be the most difficult or disturbing event, or case that could and
should be discussed. We spend a few minutes thinking how to proceed.

I do not know the case and have to be informed. People have to tell me the details of the case and in that way they share the case with each other. Chairing the meeting is the nursing officer or a sister.

We try to think about it together. I pay attention to the group dynamics issues and try to intervene in an appropriate acceptable way. Some of the cases that were discussed in this staff group are presented in some detail in Chapter 4.

Continuity

As staff work three shifts and weekends different staff will be in meetings depending on their shifts. The sense of stability and continuity had to be located in me and the nursing officer who supported the project. The sense of continuity was located in the structure, underpinned by the belief that such meetings are worthwhile. I came to think of the undertaking as a shop and myself and the nursing officer as "shop keepers" opening no matter how many customers are there.

The commitment to this work was and is regularly undermined. Comments like "there are too few staff", or "we are too busy" or "there is nothing to discuss" will come at me and sometimes there will be no meeting and some exploring than takes place as to why and what is going on.
Chairing the meetings

It seemed right that the sister or the nursing officer should do it. I am the outsider who is asked to help. Although the sister chairs the meeting there is a sense that this is a somewhat different situation from other events on the unit where she is clearly the person in charge. She is not here to show she knows the answers.

I thought it right if the chair is the nursing officer or a sister rather than myself; in that way the event does not undermine the structure of the team.

The choice of topics

As the meeting has no agenda, the topic the meeting will spend its time looking at, is chosen at the beginning of the meeting. I state the purpose of the meeting for the sake of any new comer. I say that we are here to look at the most difficult case or issue that people were upset, worried or angry about. We might not be able to solve the problem but we can try to think about it together. The chair-person then asks each member of the group to offer a topic, these are discussed and when there is agreement, that is the topic of the meeting. As an outsider who does not know the topic, the facts are then presented to me. This is an opportunity for the group to get the facts clear and think about the case or issue under discussion.

The use of the meetings

These meetings of the staff group give people some experience of sharing feelings, not knowing and acknowledging painful feelings of failure and so on. It is
a development of the journal club but it addresses issues that are currently alive and painful on the unit.

The parents support group

A further development in the project was the introduction of a parents support group. The meetings of this group were run by two sisters and myself. The detailed work is presented in Chapter 6 where the anxieties and defences experienced by parents of premature babies are looked at. What is relevant here is to say that I think this work of support of the parents is a result of the team development and it feeling supported by the work of this project.

The parents support group is a result of cooperation between the nursing staff and myself. The administrative side of the work e.g. inviting parents and chairing meetings is the job of the sister. Here too I am the outsider who is introduced as "Amira the psychotherapist of the unit who is interested in the emotional aspect of having a baby on the unit".

The meeting has two parts. In the first we listen to one another, one person speaking at a time. In the second part the staff withdraw, parents have an informal chat to each other, friendships are created, and subsequently some parents support each other after they have been discharged.

At the same time the staff and myself spend the time trying to rethink about the material that was presented to us and formulate some ideas about what was said; does anyone need to be informed? how should this parent be treated on the unit? what was the "feel" of the meeting?
Issues of the parents group work

Everybody except the sister is hearing the facts of the case presented for the first time. People are usually very moved when cases are discussed. I feel that this work helps staff be more sensitive to parents' feelings that are stirred up as a result of a premature birth. While discussing the present crises other issues in the parents' personalities and past difficulties are talked about.

Some parents chose to come for many weeks, and some come for only one meeting. It is our responsibility to be there and available at the agreed time and place. This parents support group is now part of the service that the unit offers to the families of premature babies.

It is linked to the widening of the primary task of the unit. The task used to be looking after the babies and is now looking after the babies and their families.

The language used in working with the staff and parent groups

The language used in working with staff and parents interests me a great deal and some examples of the way I address staff and parents are given in Chapters 4 and 6. Transference interpretations, the bread and butter of psycho-analytic work has to be modified in work with groups of parents or staff.

In her paper "Formulation of interpretations" Egle Laufer quotes Freud on this issue and writes "Since, however psychoanalysis cannot dispense with giving information, it lays down that this shall not be done before two
conditions have been fulfilled. First, the patient must through preparation, himself have reached the neighbourhood of what has been repressed, and secondly, he must have formed a sufficient attachment to the physician."

The staff and parents are sometimes in a very disturbed state where unconscious paranoid phantasies are felt to be concretely confused with frightening reality. Containing this phenomena in the service of holding on to the facts is what I am struggling with while in these groups, and trying to address the issues I think they are "in the neighbourhood of".

Discussion

The work of the early stage of the project felt like "pioneering" work. It seems to me that a setting, a language and a time had to be found. The challenging aspect of this stage of the work was the knowledge that there was no convention or tradition on the unit that I could use. I felt I had to find a way more or less stumbling in the dark.

The work of the early phase in action research is in my opinion not explored enough in the literature. I feel as if writers do not share with us their early struggles to find a right setting, an approach that would fit the problems they were confronted with. We are told about the unconscious resistance to new developments (Jaques, Menzies Lyth) but we are not told in any detail how the outside consultant handled the resistance to himself and to his new insight.
The difficulties of finding the right way to address issues in the staff or parents group reminds me of my work as a child analyst when confronted with a need to find a way to talk meaningfully with a very small and disturbed child.

Unlike an analyst, I cannot maintain anonymity. I am more of a real person in the unit, revealing what I stand for. For example, I brought toys of my children in order to start a toy corner for toddlers who have baby brothers or sisters on the unit. This was a deliberate attempt to act out a wish to close a gap between "them and us" and state "we, the staff also have children".

My example was then followed as if "permission" to acknowledge our ordinary humanity was given. People brought toys and knitted clothes; many other expressions of ordinary and extra ordinary concerns were noted.

Staff and parents take in this model which strengthens their trust in their internal good objects. It seems to me that their ego functioning is linked to their trust in their goodness and creatively which takes a battering when a premature birth takes place.
Chapter 3. The process of assessment of the crisis on the neo-natal unit

3.1 Introduction

The struggle to save lives of premature babies, seen in a neo-natal unit is the environment in which this study is carried out. The intense feelings that this produces in everyone concerned is the field of study. The team's problems are looked at via meetings with management, staff and student nurses. Some data is also presented through two subjective informal observations of life and death on the unit.

The formulation at the end of the first meeting

The staff convoyed a sense of wishing to flee, not coping, being overstressed, one member of staff was seen as mad, attacking the equipment.

It was possible that the staff were fleeing from the "boss" Miss D, who was no longer one of the nurses on the shop floor. It was possible that her shyness might have been taken as remote superiority; I was not convinced by this possibility. I wondered if she was felt to be rebuking the staff in similar way to the parents were felt to be telling the staff off.

Miss D was clearly worried about possible damage to the babies. I wondered if the single nurse that was mentioned as needing psychiatric help was an ill, disturbed person or was displaying her own pathology, as well as that of the unit. It seemed to me that it was possible to think about the powerful projections from the parents, who feel persecuted, into the staff who wish to flee this painful process. It was also possible to think about the staff feeling identified or even confused with the little and
ill babies who are totally dependent on the staff, their skills and the machines that keep them alive.

Segal (1957) writes "If the anxieties are too strong, a regression to the paranoid-schizoid position can occur at any stage of the individual's development and projective identification may be resorted to as a defence against anxiety. Then symbols in sublimation, revert to concrete symbolic equation, this is mainly due to the fact that in massive projective identification, the ego again becomes confused with the object, the symbol becomes confused with the thing symbolized and therefore turns into an equation". I wondered if such a process was at the root of the problem. It implied that unconsciously there was a lack of separation between subject and object and therefore a need to expel and act. Later in the same paper Segal tells us "The symbolic equation is used to deny the absence of the ideal object and to control a persecuting one". I am suggesting that there was a great lack of "ideal babies" in the unit, at that particular time, hence the regressing to symbolic equation.

It was agreed in my first meeting with the Director and her deputy that I would meet the Nursing Officer, the qualified staff and then the students nurses in separate meetings and then come back to discuss my findings with the Director and her deputy.

Collecting the data

In Chapter 2 I looked at the first phase of the project briefly reporting on the methodology of that phase. In the following I report in detail on the data, of this stage of the work, the way it was collected, its nature and my thoughts on it.

In order to find out how people felt working on the Unit I arranged a number of meetings, some with the qualified
staff and some with the neo-natal student nurses. The qualified staff who have been on the Unit for sometime had a different approach to life there, than the more fresh and inexperienced student neo-natal nurses.

The method of collecting data could be divided into two main categories:

1. Formal meetings with the staff and student nurses, in order to find the group's feelings on life on the Unit.

2. One hour observations of interactions on the Unit between members of staff and parents and between members of staff and infants in the incubator. During these occasions I hoped to see individuals' responses to working on the Unit. What was said and done was recorded outside the Unit as was the emotional tone of the meetings.

Some of my difficulties as a researcher

I touched on this issue in the previous chapter but I want to add a few words. Trying to be an objective outside observer was and is very difficult. It seems that in order to understand fully what the data is about, one has to be near enough the "heat" of the experience but not too near to think.

A borderline position is needed between being a member of the team and an outsider. The data is very often overwhelming and extremely painful and upsetting. Raw feelings are flooding and the risk of acting inappropriately is there. Projections are powerful and extremely fast. Thinking under these conditions is very difficult.

Menzies Lyth highlights the difficulties in this work writing "one exists most of the time in a state of
partially self-imposed ignorance which may feel profound, frightening and painful.

In another of her papers (1974) she tells us about the complicated difficult transference phenomena and the violent and intensive countertransference feelings she experiences in her work in groups. I found taking notes a useful way of trying to think and contain the data, which in time turned into a research project.

In time my therapeutic role in the Unit was enlarged to accommodate a research role. The data collected in a Neonatal unit is not only complicated, painful and upsetting, like any situation in a factory or other institution, but there are objective facts that generate more powerful responses in this setting than in others. There are tiny babies and their families who are going through a terrifying time. Nurses and doctors are working there and get at times almost swept away by the emotional tide that sweeps the Unit when a life and death drama unfolds. All these generate anxieties and defences that I tried to expose myself to and try to think about in the next few examples of data, collected from this early stage of this project.

Comments

This was an unusual referral. It came to the Department of Child Psychiatry in the hospital, after the Adult Department had turned it down. It was not a child referred by a psychologist or a G.P. It was a hospital unit referred by the Director of the service.

I took the referral on because of my interest in early infant-mother relation that got stirred up by two clinical facts.

I had a borderline psychotic 9 years old boy in intensive therapy who was a premature baby. The early sessions in
the treatment made me wonder about his inability to metabolise his early life experience. (Some of the work with him is looked at in Chapter 7.)

The other clinical fact was the number of "ex" neo-natal babies who were referred to Child Psychiatry as toddlers. While in the population as a whole the percentage of premature births is no more than 6% to 7% the referral rate to the special play group run by Child Psychiatry where I worked was of the order of 30%.

These facts were in my mind as I made my way to see Miss D. The meeting with the Director and her deputy produced an hypothesis and a plan. Some of the meetings, and the informal observations are looked at below.

3.2 A planned meeting with staff. Dealing with negative data

Introduction

Here I look at the need for "negative capabilities". In other words, when projections and rejection that are part of the resistance to me and what I am trying to do in the Unit and are felt to be almost overwhelming some ability to tolerate, stay the course and think about all this is required (Menzies Lyth 1986). I thought wrongly that there was no relationship as yet between myself and the staff of the Unit. At this stage of the project I had only met the Director, her deputy and the Nursing Officer of the Unit, but the need to reject any object that was threatening with thinking was there before I came in through the door.

The planned meetings

The Director of the Midwifery Service of the Health Authority invited me to meet the Nursing Officer and the Sisters on the Unit. The project was discussed and a
further two meetings were arranged. Times and place were agreed. When I turned up no one was there. I found an empty room and the situation described by the Director as "nurses running with their aprons flapping". I saw staff who appeared to be too busy treating me as if I was not there. I was ignored. Another two meetings were arranged as if nothing untoward was going on.

Countertransference feelings

It is difficult to convey the feelings of confusion and hurt pride that sets in, making it difficult to even try to clarify the facts. I was quite clear about the time and place. There was no doubt at all about the facts ..and yet .. I thought did I make a mistake? The painful attack on my senses, my professional identity made it difficult to try and think about the data.

I knew there was an agreement that some work would start. I was invited in but the fact was that no one was there. Here was evidence of rejection or resistance that occurred again and again. It needed to be tolerated and thought about. At the time I felt humiliated, if only I could vanish, blot it out of my memory.

I wondered if Miss D the work group leader who was in touch with reality felt swept aside by the feelings on the Unit. I did not take account of the fact that if that was the case I would be treated like Miss D by the basic assumption group. My feelings on these occasions were of total confusion as if I was carrying the psychotic parts of the team, and the total transaction namely who was mad and who was made to feel mad had to be hidden.
Discussion

The fight flight phenomena in the team unconscious defences

It is tempting to think that the pattern of behaviour described by the Director in the Unit was that of a group in a flight away from the "baddies" who are the damaged babies and the angry persecuted and persecuting parents who are so confused with internal damaged half dead objects; that flight was the only option.

Reality of agreed meetings is denied and a strong sense of confusion is present in me. The work group leader, Miss D is feeling ignored, I as her representative get the same treatment by the Unit under the influence of the basic assumption fight-flight phenomenon. Put in another way it seems that the team is using paranoid defences to flee a persecution of the parents who produce "nearly dead" babies, are acting out their phantasies of the strength of the death instinct and project their confusion.

Klein in her paper "Notes on some schizoid mechanisms"(1946) writes about the early anxieties "I hold that anxiety arises from the operation of the death instinct within the organism, is felt as fear of annihilation (death) and takes the form of fear of persecution. The fear of the destructive impulse seems to attach itself at once to an object - or rather it is experienced as the fear of an uncontrollable overpowering object" (p3).

I will try to show later on how the presence of a dying baby on the Unit gets fused with an internal object who represents a destructive persecuting object causing flight, a basic assumption phenomena in the Unit.

Freud in his discussion on the individual in a group states that in a group the individual's emotions become
3.3 Meeting with student nurses; projection and identification with the hospital and patients.

Introduction

One of the most lively meetings that I had at this stage of the work was with a group of new neo-natal students. These were all qualified nurses, who came to train in this field. Their difficulties at this early stage of their training were very striking, also striking was the way in which they could be made to feel somewhat freer and therefore better by a simple interpretive intervention that appeared to help the students regain their "ego functioning". The group became more lively and thoughtful.

I thought that the student nurses could empathise with their future tiny patients after an experience that helped them with their feelings of being new in a strange unit. They felt understood in the meeting with me, their identification became conscious and so available for thinking and change.

The meeting

The group consisted of 8 nurses on Course 405 training them to work in neonatal intensive care.

The meeting reported here took place on their second day on the Unit.

-116-
We were sitting in a circle and I asked people to tell us their name and something of their professional background.

4 of the students came from other hospitals in this country, two were from Ireland, two from overseas. As the meeting progressed a picture emerged. Almost all of the students felt insecure, critical, confused and lonely. Comments were "The accommodation is awful here, it used to be better where I was", "The canteen is no good, you have to pay for mustard and ketchup here, not where I come from", "There is nowhere to hang the washing, no ironing facilities, whereas in the other hospital this was better", "People are very unfriendly here, much friendlier where I come from".

The sense was that of resentment, persecution, and some hopelessness. They had not got to know each other yet, and felt lonely and lost.

Interpretative Intervention

I said that listening to them I was struck by how similar their feelings were to that of the babies. The babies if they could speak might say that the accommodation here is far inferior to the one they had been in before namely, their mother's uterus. The babies might have felt that in "the other place" their needs were provided for and that they "did not have to pay for mustard", whereas here they do not know if there is any form of "canteen" let alone if there is any mustard.

My comments provoked some smiles and comments. One student nurse said: "Yes babies can also feel. They suffer". Others
agreed and a discussion started about feelings and how babies feel pain, cold and loneliness.

I said that I was not trying to say that they were babies, but I think that they become for a while flooded perhaps with feelings similar to those of insecure babies. If the feelings are too powerful they might prevent the students from finding out all they need to know about facilities for ironing or washing. The feelings become believed in and the students might be trapped in the belief of the truth of this picture and cannot ask where is the canteen.

It is interesting to think about the process we saw in front of us. It was quite striking to see that when the unconscious process of projection and introjective identification was made conscious, and was discussed some relief was noted and the group became more lively as if it had regained its abilities that for a while, when in its state of identification with weak fragile babies, were not there.

Coming into close contact with very ill and frail babies seemed to reinforce the frail persecuted part of the students who felt lonely, threatened and "starved" of understanding and love. They quickly recovered the "ego" function of their personalities when their feelings were acknowledged, then we witnessed some empathy and thoughtfulness with the babies plight.

Discussion

Laplanche and Pontalis define Identification as a "psychological process whereby the subject assimilates an aspect, property or attribute of the other and is
transformed, wholly or partially, after the model the other provides. It is by means of a series of identifications that the personality is constituted and specified" (1980).

Projection

Klein sees this as a very important early defence against anxiety linked to splitting and introjection. She states "Projection, as Freud described, originates from the deflection of the death instinct out-wards and in my view it helps the ego to overcome anxiety by ridding it of danger and badness. Introjection of the good object is also used by the ego as a defence against anxiety" (1946). The students, coming to a new hospital and into contact with the ill babies on the unit are projecting the danger they feel into the complaints about the accommodation and the canteen. It seems an unconscious process.

An oral element in early persecutory fear is based on aggressive unconscious phantasies of emptying and biting the "breast", which lead to the establishment of the prototype of an aggressive object relation which Klein calls projective identification (ibid).

The student nurses in their first meeting with me expressed strong anxieties with an oral undertone. The canteen was either nowhere to be found or inadequate, they had to pay for mustard and ketchup, it was dirty and unfriendly.
Converting the process of projective identification into a communication

It was Bion in his highly original papers in the late fifties and early sixties who made the important distinction between normal and abnormal projective identification and spelled out that the outcome of this process depends on the ability of the mother to introject the data and return it to the infant in a modified state.

In his paper "A Theory of Thinking" he writes "Normal development follows if the relationship between infant and breast permits the infant to project a feeling, say that it is dying, into the the mother and to reintroject it after its sojourn in the breast has made it tolerable to the infant psyche. If the projection is not accepted by the mother the infant feels that its feeling that it is dying is stripped of such meaning as it has. It therefore reintrojects, not a fear of dying made tolerable, but a nameless dread. ...The establishment internally of a projective identification-rejection object means that instead of an understanding object the infant has a wilfully misunderstanding object with which it is identified"(1962). The new nurses reported early on in our meeting that they felt there was no understanding object for them. They were at a risk of feeling that "a no object" was there, which points to the danger Bion shows in his paper of the group sliding into a feeling that their feelings are stripped of meaning.

Summary

A clinical meeting with the student nurses on the unit displays their conflict. Their position of being new on the unit gets aggravated by the meeting with the frail
premature babies. I suggest that this stirs in the group feelings of helplessness, anger and loneliness. There is a risk that the feelings will overwhelm and be confused with reality.

The projection into the "hospital", is an attempt to get rid of an unconscious anxiety of the group. The hospital is seen and felt to be a persecuting uncaring object.

When this projection and identification are made conscious there is a sense of relief in the group, that feels that some understanding object appeared. The "Ego function" of the group is somewhat restored. There is an experience that the group is freer to think and be separated from the patients. I suggest that this way of working might be a way of helping nurses get in touch with their difficulties and allow them to empathise with the feelings of their patients. This section highlights the way I worked later on in this project. I use some analytic understanding to try and free the "Ego function" of the staff. At this stage of the project I am using this account to show the identification and projections of the new students.
3.4 First informal visit: Evidence of part object culture.

Introduction

In this section I move right into the heart of the Unit. The observation takes place in an intensive care room. The interaction is between three members of the nursing staff and a baby. Intense feelings come to the surface, my counter transference feelings in this hour are noted. I describe some of the powerful emotional dynamics that operate in this setting and consider the causes and their effects.

Observation

I went into the special care room where a staff nurse was working.

The nurse's hands were inside the incubator. A baby could be seen crying, clenching his fists and moving his legs and face. His cries could not be heard because the noises get totally subdued by the glass.

There were two other babies asleep in the room. I stood near the nurse who was trying to insert a nasal tube into the baby's nose. The nurse told me that the baby is very active and he had pulled the tube out, and now she has to put another one in. The nurse said how difficult it was and that, the baby hated it. The plaster on his cheek was not sticking and the tube was not secure. "He is hating it" she said. She seemed uncomfortable. She seemed worried about the baby's feelings. I felt she needed some support
and said "It must be necessary...he will get his feed via the tube". I wondered if she felt guilty about inflicting pain and causing the baby's discomfort, or about being seen to fuss? This took a few minutes.

Another nurse came into the room. She stood for a minute near the first nurse looking and seeing the activity by the incubator. She suggested to the first nurse "try and stroke his cheek, it might calm him...or stroke his head". A minute later she went out of the room.

By then the tube was inserted and milk was being given through it. The nurse was holding the tube with milk; the sense of discomfort was abated. The nurse who seemed somewhat relieved was talking to me and said "I think they must hate being here with the tube...their life is so uncomfortable...first the ventilator then this, it is so unfair...".

The mood seemed calmer and the nurse who felt that she had inflicted pain was now feeding and feeling that she could comfort and help. I thought that this was very important to her. She struck me as sensitive to the baby's feelings. Her sense of herself as a caring, helping nurse was tested when she felt she inflicted pain, as if the crying baby was felt to reproach her and accuse her of being cruel. Feeding was reassuring maybe for the baby and reparative for her. It restored her sense of being a caring good nurse. This is the sort of moment I thought that might have been one of the reasons for her choosing to become a nurse.

She was about to put the second portion of milk into the tube when another nurse entered the room. From the door of the room she said "Go for lunch I will finish here". The
first nurse said: "It's O.K. I only have this portion to do, it will not take long". It sounded to me as if she did not want to go for lunch but wanted to finish feeding the baby she felt she had hurt.

Was the newcomer a more senior nurse? I could not see from the uniform. But the newcomer insisted "Go, go on, how much does he take?" There was a sense that she did not know the baby, nor that she had looked after him, nor had suffered with him.

The first nurse gave up. She handed the tube to the newcomer who by then was at the incubator and she asked as the first nurse was leaving "how much does he take?" The first nurse went back to give the information.

The atmosphere around incubator changed dramatically. The arrival of the newcomer brought a new approach and attitude. The place changed from a place where suffering was acknowledged, attempts at repairing made, to a cold almost mechanical place where a hole (the tube in the baby's nose) was stuffed with a meaningless "thing". It seemed to me that a stripping of meaning took place, together with a denying of pain and individual needs.

I left very soon afterwards and in the corridor met the first nurse on her way to lunch. She avoided looking at me, our conversation as well as the feed had been interrupted in the middle of the sentence. I felt a bit sad and confused as I left the unit.

Discussion

It seemed a fairly typical every day interaction on the Unit. It seemed to be a place where contact and
relationship were open to interference. Feelings, anybody's feelings were devalued and ignored, and continuity of treatment was not considered worth preserving.

The third nurse was advocating the belief that people are interchangeable; one pair of hands is as good as another. One baby is the same as another.

I thought that the Unit was in the grip of a part object culture. Whilst the first and second nurses where trying to resist this they were defeated. The first nurse allowed herself to be pushed out of her role as the feeding nurse.

The dominating culture seemed to be that of a part object phenomena in the clutches of anti-meaning and anti-linking between a baby and a nurse or between a nurse and her own needs to feel she can feed and comfort after she caused pain.

Attacks on linking

Bion's work on thinking and thought disorders in his wonderful papers from the fifties are a development of Freud's work in "Formulation on the two principles of mental functioning" (S.E. 19) and "Neurosis and Psychosis" (1924) and Klein's work in "Notes on some schizoid mechanisms" (1946). In his paper "Differentiation of the psychotic from the non-psychotic personalities" (1957) Bion tells us about the attacks on thinking by the psychotic part of the personality not only on thoughts but on the thought process itself "In fact, not only is primitive thought attacked because it links sense-impressions of reality with consciousness but, thanks to the psychotic's over-endowment with destructiveness, the
splitting processes are extended to the links within the thought processes themselves. As Freud's phrase regarding thought being turned to the relations between object-impressions implies, this primitive matrix of ideographs from which thought springs contains within itself links between one ideograph and another. All these are now attacked till finally two objects cannot be brought together in a way which leaves each object with its intrinsic qualities intact and yet able, by their conjunction to produce a new mental object" (p 50).

The psychotic process occurs according to Bion when there is a destruction of those parts of the mind that are capable of knowing and being aware of internal and external reality.

According to O'Shaughnessy (1981) Bion places the emotional experience of trying to know the self and others in the centre of mental life and links the reality principal and the pleasure principal on par with the life and death instinct.

Summary

An interaction between a nurse and an ill baby is presented. The interaction is open to interruption of other staff. This interaction is looked at via countertransference response as well as through the facts of the interaction.

I am suggesting that the hating of knowing about pain, fear, and of being small is what we see working in this example. It overcomes and attacks an attempt at a meaningful contact. The arrival of the third nurse strips
the painful meaning of the contact between the first nurse and her little patient.

It also denies the nurse's contact with her own emotional reality, namely her need and wish to feed and thus make better the hurt she felt she had inflicted on her patient. The interaction between the first nurse and myself is exposed to the same fate as her interaction with her patient and her contact with her own needs.

3.5 Second informal visit: The impact of a dying baby on the team.

Introduction

In this section I shall describe a visit dominated by a dying baby and its impact on the team and me. It seemed to have been a watershed visit. The death and the way it was handled or mishandled, the phantasies it provoked and the defences used are looked at. In retrospect I feel that this had a long term impact on me and propelled me into some of the actions that became a part of this project.

The observation

I was told by a nurse that there was a dying baby on the Unit. Her name was Clair, she was dying from spina bifida complications. She has been on the unit for 3 weeks, a full term baby. It was not spelled out to me at the time but I understood later that she was fed only when she appeared to be hungry and no active medication was given.
I was aware of the feeling that something awful was taking place, or that the nurse was trying not to dwell too long on an awful situation. Years later I still think of this as one of the most difficult situations for anyone to bear.

I went into the little cubicle where Clair was. I was aware of my own fears and questions; what would I see? Would there be a very obviously damaged, perhaps revolting baby? The shock I felt when entering the cubical was that I was faced with a beautiful, full term blond baby. She was covered in a pink blanket, appeared to be asleep with her mouth moving as if looking for an object. Eyes closed, pink cheeks, a little snub nose and a head of fine blond hair.

Was she dying? I found it difficult to believe. There was nothing visible...How does a baby look when dying? I put this question to the nurse who was standing next to me.

The nurse, a middle aged woman with an ashen face, somewhat stern and flat, told me about the change in the colour of the baby as it is dying. She went on to say in a matter of fact, vacant voice that the nurses were waiting for her to die. They hope she will not be there when they come on to their shift. The worst part is having to wash the body and put a paper nighty on her and put her in a box for the porter to take to the mortuary.

We were standing, the two of us looking at this baby, next to her a pink teddy and a card saying "Mummy and Daddy love you Clair". At this moment grief overcame me and tears came to my eyes I was thinking, such a small
baby came into this world for such a short time, suffering so much.

The Nursing Officer came into the cubicle and the nurse was complaining "Look, she is hungry she wants to eat" she said to the Nursing Officer in a somewhat accusing way. The Nursing Officer said "O.K. feed her when she wakes".

I left the cubicle, I saw the blue sky outside, the babies who were getting better, thought about my kids at school, felt very sad and lucky as I was leaving the Unit.

Discussion

Unconscious Conflict enacted in the Unit

It seemed to me that the nurse was protesting that it was too much. She could not tolerate a baby being starved to death. It was too much and too difficult. The nurses want to preserve life, they are not trained to help babies to die. The nurse in the room with me might have been identified with the parents who desperately tried to deny the death by putting a pink teddy in the incubator and leaving a card saying "Mummy and Daddy love you Clair" as if they hoped the baby would be able to play with the toy? She, the nurse and the parents wanted a magic, omnipotent cure. Let us feed her and thus make her better, was the undertone of the nurse's message to the Nursing Officer. She will live! The Nursing Officer gave in, under the pressure of the accusation, and the suffering continued. The baby was not getting better, it took another ten days before Clair died.

-129-
There was a rebellious atmosphere outside the Unit. The Nursing Officer complained that instructions were not being obeyed. Staff appeared not to listen to her. Her authority she felt was questioned.

It seemed to me that the nurses felt they were told to kill the baby. They resented this and felt identified with the baby. They rebelled on her behalf as well as on their own behalf, were confused with her, and perhaps felt also identified with her parents too. It seemed that the Nursing Officer was perceived as the hated figure who was responsible for the tragedy. Unconsciously she was the bad murdering figure containing all the badness of the team.

Social system as a defence against paranoid anxiety

In his 1955 paper Jaques describes a social structure as a defence mechanism against paranoid anxieties. He stresses the gain for the team if a member is able and willing to contain the projection and is then reintrojected by the other members of the team thus sharing the feelings that the attack was acceptable to the team and to that particular member of the team. I think that the Nursing Officer was unable to tolerate the level of projection that was necessary in the face of Clair's death.

Attack on meaning

A sense of stripping the baby of her dignity was vividly conveyed to me when the nurse was describing the washing of the dead body and "putting it in a paper nighty in a box". Here, I felt was the process of depriving the baby's life of its meaning, a kind of emotional death. It
was then in the process of turning from a baby into a "thing".

In the film "Shoa" by Claude Landsman there is an account of two prisoners from a concentration camp who were told to open up a mass grave, dig up the bodies and burn them so as to wipe out any trace of what had occurred. One prisoner found buried there his own wife and children. He said that the guards did not allow him to say the words "bodies" when talking about what was in the grave. The prisoners were beaten up if the words "grave, or dead bodies" were uttered. I wondered if some "nazified" process was taking place when the nurse felt that she was asked to "starve the baby to death" and she felt terribly guilty and extremely resentful as if she had been told to deny that a death of a baby was taking place and she felt as if she was murdering the baby and her life meaning.

It seems that guilt or other feelings made it impossible to bear the pain. The nurse in her flat description of what was to become of Clair's body was getting rid of her pain as well as her ability to think and feel. There was a sense of cruel devaluation in the account. Why a paper nighty? Why a box and not a coffin? It was not possible for me to think and clarify this for myself for a very long time. It felt as if I was being told about a deadening course of action.

The nurse conveyed the impression that this was an activity done by an outside agency to the baby. I wondered if the persecution was in part a statement of how the nurse felt about what she was involved in doing. I wondered if for a good nurse the task of looking after a baby in this way on the Unit has the meaning of stripping the baby's life of any meaning and therefore the nurse,
in identifying with the baby and her fate feels herself treated in the same way by her Nursing Officer, and thus a most vicious circle is created.

I find Bion's work central to understanding the interaction between the nurse and me. There was clearly no object that could take the projections and offer them back in a modified way to the staff. If that was the case, "If the mother cannot tolerate these projections the infant is reduced to continued projective identification carries out with increasing force and frequency. The increased force seems to denude the projection of its penumbra of meaning. Reintrojection is effected with similar force and frequency". Infant or patient or nurse in that situation then "behaves as if it felt that an internal object has been built up that has the characteristics of a greedy vagina-like breast that strips of its goodness all that the infant receives or gives leaving only degenerate objects" (1962). He continues "The tasks that the breakdown in the mother's capacity for reverie have left unfinished are imposed on the rudimentary consciousness,....The rudimentary consciousness cannot carry the burden placed on it. The establishment internally of a projective-identification-rejecting object means that instead of an understanding object- the infant has a wilfully misunderstanding object- with which it is identified. Further its psychic qualities are perceived by a precocious and fragile consciousness"(ibid).

Relation between Staff and the Nursing Officer in the Unit

The Nursing Officer being full of the projection of the powerful hate and anxieties of her team was unreliable for the team to project into and to introject as a tolerating
thinking parental figure. Instead they were left without a thinking absorbing object, or according to Bion, an object that stripped their experience of its meaning, leaving it as meaningless, and themselves as empty of goodness or full with damaging and damaged internal objects which in turn they needed to rid themselves of, and then turn to attack their own thinking abilities.

A dying baby as an unconscious bad object

A baby that is dying on the Unit, or put more bluntly left on the Unit to die from among other things hunger is an awful burden for her parents and the staff to carry.

If that is the case there will be an unconscious wish to get rid of it i.e. destroy her and the memory of her, and thinking and remembering in general.

Segal states "Where such symbolic equations are formed in relation to bad objects, an attempt is made to deal with them as with the original object, that is by total annihilation and scotomata" (1957).

It seemed to me that this was such a disturbing task that a collapse took place in the team's ability to function. The mother figure was felt not to be able to take and absorb the fear of dying or murdering that was present in the team. In fact this member of staff left the Unit at the end of the month very shortly after Clair's death.

Summary

The event of a very ill baby dying on the Unit is looked at. The relationship between the staff and the Nursing
Officer shows the powerful projection of bad aggressive impulses into her. It left the nurses without an object that could tolerate the meaning of the event on the Unit. It seems that there was a struggle against a perception held by the staff that they were to strip the life and death of a baby of all meaning; that they are to act as if members of a Nazi organization. It seems that the dying baby became unconsciously confused with dying damaged attacked objects (Segal), and thus an almost catastrophic situation was set to develop where life was devalued to a very dangerously low point, and the ability to feel and think was attacked in an attempt, perhaps, to get relief from the horror that was unfolding.
3.6 The essence of the problem

Formulation

The work of the Unit with ill very frail or dying babies can stir up unconscious worries about internal attacked or dying objects. The reality of the task of the Unit is so close to unconscious phantasies and anxieties that symbolic equation is rife resulting in a concrete way of thinking.

Also it is terribly difficult for the nursing staff to offer a container for the parents' projections if there is no container available for them. I show an example where this does not take place and the object instead of helping in metabolising the data is perceived as stripping the subject, in this case the nurse of her goodness leaving her with only degenerate objects.

The dying baby obscured the reality of the recovering and growing infants. I felt I had to leave the Unit and remind myself of my living healthy children. The Unit in a crisis was felt to be dominated by bleak hopelessness.

The observations were shared with Management. It seemed that while individual nurses were sensitive and caring human beings, the team was unable to provide a caring thinking and feeling environment for its patients and its own members. A culture of splitting and part object was dominating. A process of devaluing peoples' feelings and babies' lives had taken hold. There was no 'object' who was willing to take on the projections of bad aggressive impulses (Jaques), or able to introject and return them in a somewhat contained form (Bion). No place or opportunity to develop awareness was there, as the
"ego function" of the team was overwhelmed by the unconscious conviction of the strength and triumph of the death instinct.

Some insight and concern was located outside in the Director of the service who sensed that this unit could become a dangerous place. The ego strength of the team needed supporting by providing a "good" experience that could be taken in and identified with. The culture needed reversing urgently. The how and what and when of this process of reversal was looked at in Chapter 2 and is developed further below.
Chapter 4. The work of the Staff Group
4.1 Starting a Staff Group

In this chapter I look at the third stage of my work with the staff. Following a period of assessment, a period of creating a setting in the Unit via a Journal Club, and the other interventions mentioned above, I felt that it was possible to try and create a Staff Group. It would meet regularly to work on issues that came up as a result of the work of the Unit and would try to identify and deal with the anxieties of the team.

In detailed clinical material I will show the acute anxieties present and the powerful primitive defences used. I then describe attempts to change the defensive systems employed, via the work of the Staff Group, and the resulting, gradual change in the Unit's perception of its task from one of caring for the babies to one of caring for the babies and their families. Also discussed is the struggle of the staff to face not being able to save all babies. In other words the task of the Unit changed from the unrealistic primitive one to one linked more to reality.

Even superficially the atmosphere in the Unit was sometimes very tense, or very brittle somewhat manic, at other times depression hung heavily in the air. And this mood, as the tip of the iceberg provided evidence of deep dangerous defensive structures moving in the unconscious of the team.

Early on in my work, I used to listen and look at Grace, the Unit's domestic help, as a form of "human barometer." If she was singing while cleaning in the Unit's corridor,
I thought that things were OK that day at least superficially.

The work of Menzies Lyth (1959,1973) takes us through the defence structure of the nursing profession, exposing anxieties of nurses and the defences that were mobilised by the staff through the organizations of the work with the patients and the relations between the qualified staff and the students.

Starting a Staff Group

The nature of the anxieties that staff have to deal with in themselves and in the families of their baby patients is at the centre of this chapter. In the next 4 sections, I look at the specific anxieties that permeate a Neonatal Unit.

Feeling of sympathy and pity, superiority and contempt towards the parents as well as feelings of sadness and compassion for the sick babies and sometimes anger, frustration or murderousness are known to exist. These strong feelings are usually covered up and defended against.

I thought that a Staff Group, meeting regularly, would show clear and detailed clinical data about the feelings that are to be found in the group on the Unit. It would gave me a chance to get hold of the emotional out-flow of conscious and unconscious phantasies. Having some understanding I hoped I might be able to intervene in an attempt to contain and bring about some change.

After the work in the Journal Club and in other areas with the team reported in the previous chapter, it seemed that
the time was right to move towards a Staff Group. I had in mind a "Work group" that would address issues as they arose from clinical work on the Unit in a freer way than in the Journal Club. The discussion was not to be based on a prepared paper or presentation but the topic was to be decided by the people assembled at the time.

I approached the Nursing Officer. It was agreed that a monthly meeting would take place, that she or one of the Sisters would chair the meeting, that it would take place on the Unit and whoever was free would be expected to come. To start with some doctors used to come but on the whole it was a Nursing staff meeting. The meetings now take place twice a month and between 6 to 8 nurses attend.

The lack of continuity

As stated before the nurses work three shifts a day. Therefore a meeting that takes place on a Friday afternoon will have different nurses attending at every meeting. Is it right to call this event a Staff Group? The members of the Unit are fairly stable but different members attend each meeting.

Bion seems to say that this is not a factor that should disqualify it from being called a Staff Group.

He states "McDougall and Le Bon seem to speak as if group psychology comes into being only when a number of people are collected together in one place at one time and Freud does not disavow this. For my part this is not necessary except to make study possible...Only by coming together are adequate conditions provided for the demonstration of the characteristics of the group;...The congregation of the group in a particular place at a particular time is
for these mechanical reasons, important, but it has no significance for the production of group phenomena" (1961). For me the team that works on the Unit is the group that I am attempting to work with. The people who come to the meetings with me are part of the bigger group. Work in the meetings influences the work of the team as a whole.

Other sources of continuity

It seemed that the continuity had to come from another source, that the Nursing Officer and myself would carry the responsibility of being there at the meetings to provide the sense of continuity. We discussed it a number of times and it was a somewhat difficult and new concept to introduce. I put it to her that we should hold the meetings no matter how many people could be spared, even with one or two members of staff, that we should build it into the time table of the team and we should safeguard the time and the place.

Many times I was told "There are only the students and 2 or 3 people who can come, should we go ahead? or should we cancel?" I felt I had to "fight" to protect this concept. The lack of continuity permeates the whole of a nurse's life on the Unit. The shifts she works or the babies she cares for might change from day to day. I had in mind trying to build a sense of continuity that springs from a sense of belonging to the same team, one that shares goals and beliefs.
Distinguishing between an attack on the work and a real emergency on the Unit.

Initially it was difficult to distinguish between what felt like attacks of resistance on the work and real emergencies and to protect the meetings from such attacks. This still holds true, as attacks on my work have to be taken like attacks in analytic work, part and parcel of the set up. People act their feelings. It still often feels that I am tested every now and again pushed aside, rejected and made to feel not needed, or not sure what is going on. There are situations that come very rarely (about once or twice a year) when staff are extremely busy and the Unit is overwhelmed with very ill babies. Then a meeting is cancelled and instead I spend my time in the incubator room talking to staff or parents or observing the babies.

I think that the narcissistic pain described above is part of the setup. I try to make some use of it but do not always succeed. I find this work more difficult than psycho-analytic work, containing and thinking about the data more confusing. The professional team on the Unit undergoes many fluctuations, at times it is more united and at times less so, at times interested and available for work and at times not. A further factor is that the medical team changes regularly. This means that the Unit has a fairly stable nursing group but a changing medical one.

My aim was to help create a culture that would have strength to be transferred from the existing group of people who work on the Unit to subsequent groups as intact as possible, as in a relay race.
The structure of the Staff Group meetings

Over time I noticed that the meetings tended to have a sort of "shape". The meeting usually is chaired by a Sister and there are some new people like new students or visitors and I am introduced as "Amira, she is the psychotherapist and she looks after all of us." I then try to say in a minute or so what the function of the meeting is and after some pause a topic is offered and discussed and when there is agreement we settle down to spend our hour with the topic. It is usually a very painful case, difficulties with parents or inter-disciplinary issues.

I try to use what insight I can gather and use language that I think is appropriate. I will illustrate this in the clinical presentations below.

Summary

The specific anxieties that fill a Neo-natal Unit world can be picked up in a Staff Group meeting, with no agenda and with an atmosphere as facilitating to free interchange as possible. In the previous chapter I tried to show the work that I felt had to be done before such a group could be attempted.

Some of the unconscious resistance to this work which is of course ongoing is understood with the insightful ideas of Menzies Lyth and others. In the following I want to show the way I implemented them in the specific clinical situation of the Neo-natal Unit.
4.2 First clinical example. The use of idealisation and denial.

Introduction

The work on the case reported below took many hours. It included informal meetings with parents by the incubators formal meeting with them alone and with the Consultant, meetings with Sisters, nurses and doctors in the corridor and so on. The case is part of the Unit "legends" now. Three years on it still gets referred to as a case we learned a lot from.

When reality becomes unbearable, powerful defences are mobilised by parents and staff. Both groups drive each other mad in trying to deny the painful truth. In this case the mother was driven by an urgent wish to believe she gave birth to two healthy babies. The staff wanted to believe they could save and restore life. It was a gradual and painful process into the bleak reality that Fiona had no chance to live. The omnipotent wishes of everybody were stirred up. In the following I will describe the clinical background and the work of the group in trying to grapple with the painful facts.

Clinical background

Miss G became very ill with very high blood pressure when she was pregnant. She was admitted into hospital. She got worse, there was a risk to her life and she had an emergency Caesarean operation. Her twin daughters were born at 27 weeks gestation.
Miss G was in her mid thirties, she lived with Tony, her unemployed younger boy friend.

She had lost her father when she was 14, her mother remarried soon afterwards. Miss G became very promiscuous and took various drugs. At the age of 19 she married, was married for a number of years, left her husband and eventually she started living with Tony a young man who came to the shop where she worked, they started the affair immediately after they met.

All this was told to me in a great sense of mania in one of my meetings with Miss G on the Unit. She conveyed a feeling of a hysterical and highly strung woman that made me wonder about a somewhat hidden deep depression. Tony would one day become a great musician, he did not need to train he had talent! I was told by Miss G. that

She tried to convince herself and make everyone else believe in her own truth. Miss G and her partner had not lived in the area for very long. They did not have a helping network of relations. Tony ran away from home when he was 16 years old, lived in a bed-sit and on the streets, "did drugs", had lots of girl friends. His father was an alcoholic and grandmother was a highly obsessive and compulsive woman, who just spent her life cleaning.

The babies were desperately important for Miss G. It is impossible for me to convey the sense of terror that came over her when she sometimes came close to thinking she had "failed" yet again. They were meant to rescue her from total threat of a depressive or manic breakdown. All she ever wanted she said was to have healthy children, everybody but herself had managed. She said that when she went in the street she saw fat women who have 4 healthy
children and look at her! weeks, months in hospital! Her life was spent on the Unit. That was a statement I came to hear often followed by a sense of rage, tears and shouts and ending with her running out of the Unit. She did not mind, let the babies be killed! she would sometimes yell.

The twins were born at Edgware and were brought to the Unit and stayed on the Unit for 7 months. They were in intensive care on ventilators for some weeks. There were bad bleeds in both babies brains. Fiona the iller of the twins had to be moved to Great Ormond Street to have a shant put in her head as she developed hydrocephalus. ("putting in a shant" is a surgical procedure to drain the fluids from the brain). The mother was having very violent mood swings. She was very manic most of the time. She would claim that her babies were beautiful, were doing fine, they had even started to talk and to show preferences for particular nurses. She dressed them in most attractive dresses with nice ribbons on their heads. She tried very hard to convince herself and others that all was going to be O.K. and that the babies she produced were as beautiful as the clothes she made for them. The staff, the nurses and doctors and to some extent, I got sucked into this process of idealization and denial of sad painful truth. There was an enormous pressure to treat this family as "special" some nurses were "chosen " to look after Miss G. I came see them on their own more often than other parents. The Consultant spent more time with them than with the other families. We got to hear about it in the Parents Group and realised that we are getting sucked into a system where the staff who were chosen felt privileged? loved? or specially trained.

In the "The Ailment" Main tells us about the early object relation of such patients, who like infants had a self
centred view of the world. The patient could not manage and therefore felt it was giving a great honour to the nurse who did that for her, and the nurse felt this honour. Main brings Balint's description of the infant who needs his mother to manage the world and his body for him and he also needs to believe that this is the mother's greatest joy. He needs to believe that mother has no other wish but to be at one with him.

The work with the staff on the case of baby Fiona

When an awfully difficult case like this is on the Unit for months something takes place in the parents and the staff. I think a collusive process gets established, whereby no one faces reality. Mother is able because of her suffering and the sense of guilt that this provokes in the staff to become detached from reality and everybody colludes, from the consultant to the cleaner. No one has the courage to say that this is not a baby that can live.

Guilt and omnipotence (sometimes of a young consultant) plays havoc and the Unit itself becomes ill.

Like all the others I was under pressure too, to join in this collusive process and for a while did join in.

One of my tasks was to act as a sort of go-between between the staff and the parents. After one of my meetings with the parents it became clear to me that they knew Fiona was not going to live. They told me that they had returned the twin buggy to "Mother-Care". "We know she is not coming home and will never leave the Unit, but we cannot tell the doctor he is trying so hard". As if care was projected into him, and he was felt to have the same
feelings as they were supposed to have, they worried how would he the consultant cope with Fiona's death.

I decided to tell the doctor what my impression was of the parents state of mind. It seemed to help him and he switched off the ventilator. Fiona died two hours later having lived for 7 months on the Unit.

When Fiona died a lot of the staff went to the mortuary. I was told when the funeral would be and for a while really tried to change my time-table so that I could attend and let the parents have "a lovely funeral". I felt almost completely taken over by this case and the guilt that was provoked.

The next task I thought was how to help the staff deal with the powerful projection of guilt, depression and the idealization and denial that were so profound and below I describe some details of the staff meeting that took place after Fiona died.

In the Staff Group meeting.

B. an experienced Sister was saying "I am very angry with the mother I think she is a manipulator she just takes from everybody. She phoned the other mothers and the consultant gives her much more attention than he gives the other babies and the other mothers noticed and started saying so to me. I really feel very sorry for this mother but have to let off steam here then I can be nice to her." Another Sister said "The mother was always saying, look what pretty legs and pretty bottom Fiona has! she is so pretty...!"
The truth was that Fiona was hydrocephalic and had a very large head. It seemed to me that her mother was trying to turn a blind eye to the area of awful damage, the head, and was directing everybody to agree with her in trying to deny and not see the damage, while idealising the buttocks. I said to the staff that I thought that we were all trying to avoid seeing the terrible truth, the damage and the death and we were all trying to see the nice parts. Jo said "Is that bad?" I said I felt that it was only bad if we got to think that there was no ugly or frightening or sad facts; Fiona was dead, we all turn away from death. Culturally we put flowers on a coffin so as to not see the evidence of death.

Bee said "I did go to the mortuary and Fiona looked pretty she was not blue and mother put a nice dress on her so she did look pretty."

I did not say anything any more but thought about the need to think pretty thoughts at this meeting and after a while said "Something like this is going on at home at the moment with my husband's car. It is very old, the sun roof leaks, the windows do not open, it is rusty, but my husband is very attached to it. He keeps saying "but listen to the engine, it sounds beautiful it really pulls well."

The verdict of the garage was that it did not pass the M.O.T. test, and my husband had to face that. There were some smiles, other people brought examples of similar situations. I brought this trivial example of turning to disavowal in order to show that this is a human defence we all use, the staff were interested and amused by my husband's feelings towards his car. The idealization and denial of Miss G. is often referred to and there is a sense
that some people took this in as it came up in later staff meetings.

Discussion

Idealization

Freud examines the relation between forming an ideal and sublimation. "Sublimation is a process that concerns object-libido and consists in the instinct's directing itself towards an aim other than, and remote from that of the sexual satisfaction;...Idealization is a process that concerns the object, by it, that object, with out any alteration in its nature, is aggrandized and exalted in the subject's mind. Idealization is possible in the sphere of ego libido as well as in that of object libido. For example, the sexual over valuation of an object is an idealization of it" (S.E.14 1914 p112). Freud shows the link between idealization and narcissism in Group Psychology (1920,S.E.18) " In the phenomenon of sexual over valuation the fact that the loved object enjoys a certain amount of freedom from criticisms, and that all its characteristics are valued more highly than those of people who are not loved or that its own were at a time when it itself was not loved....The tendency which falsifies judgement in this respect is that of idealization. But now it is easier for us to find our bearings. We see that the object is being treated in the same way; as our own ego, so that when we are in love a considerable amount of narcissistic libido overflows on to the object".

It seems to me that when the object is a baby, the narcissistic libido that overflows is very great indeed.

-149-
When as in this case, the object is damaged and incomplete, the narcissistic injury is profound and requires powerful defences. The baby is on one hand "over valued" because it is a narcissistically endowed object and on the other hand is very damaged. The ego of the mother has to go into "over drive" to deal with this terribly difficult truth. She moved instantly, I think psychotic defences like manic denial and hallucinatory attempts at controlling reality were operating. Miss G needed desperately a healthy baby to reassure her about the damage she has done to her own body (drugs, promiscuity, attacks on her mother,) and felt she has done to her internal objects. Traumatised by the truth of what took place she overlooked the damage and tried very hard to get the Unit to collude. For some considerable time she succeeded. The mother projected her depression and persecution into the staff who had to deal with their own sense of failure as staff or women or both.

Klein (1952) looks at idealization as an early defence against destructive aggressive instincts, part of the early splitting of the object and the ego in the paranoid schizoid position. Klein writes about idealization as a hallucinatory gratification where frustration and anxiety derived from various sources are done away with, "In wish-fulfilling hallucination, a number of fundamental mechanisms and defences come into play. One of them is the omnipotent control of the internal and external object, for the ego assumes complete possession of both the external and internal breast. Furthermore, in hallucination the persecuting breast is kept widely apart from the ideal breast, and the experience of being frustrated from the experience of being gratified. It seems that such a cleavage, which amounts to a splitting of the object and of the feelings towards it is linked
with the process of denial". (p 65, Envy and Gratitude and Other Works 1946-1963) Miss G was sometimes unable to bear a fact reported by a nurse that Fiona had not been well the previous night. She tried very hard to see the healthy pretty parts of Fiona. A statement that she was not well could trigger shouting from Miss G "Kill her then, kill her what are you waiting for, and then she would storm out shouting and in tears. It seemed that Miss G felt attacked by the truth that shattered the split and broke through the idealization and denial. I wondered about how close she was to suicide or a breakdown.

Denial

Disavowal (denial) is defined as "The term used by Freud in the specific sense of a mode of defence which consists in the subject's refusing to recognise the reality of a traumatic perception." (Laplanche and Pontalis 1980).

Edith Jacobson discusses the relation between denial and repression and states that "a deficient repressive ability of the ego in borderline and psychotic patients brings the use of denial". She refers to Eissler's paper "An unusual Function of an Amnesia" (1955) in which he says about his patient amnesia that it "had the function not only of denying that she had suffered a trauma, but also of experiencing the world as one in which no trauma can occur". Jacobson states "In fact, it seems characteristic of denial that to begin with the ego reacts to the danger signal by an immediate attempt to ignore this very signal itself. I am inclined to believe that this immediate, initial denial of the danger signal is what prevents the ego from embarking on a true defensive struggle. Instead of expelling the inimical drives from its realm, all the ego can do is to deny their presence or
the dangerous, painful impact of the drive invasion" (ibid 1987 p122).

Klein sees denial as very primitive defence: "Denial in its most extreme form—as we find it in hallucinatory gratification—amounts to an annihilation of any frustrating object or situation, and is thus bound up with the strong feeling of omnipotence which obtains in the early stages of life. The situation of being frustrated, the object which causes it, the bad feelings to which frustration gives rise (as well as split-off parts of the ego are felt to have gone out of existence, to have been annihilated, and by these means gratification and relief from persecutory anxiety are obtained. Annihilation of the persecutory object and of a persecutory situation is bound up with omnipotent control of the object in its most extreme form. I would suggest that in some measure these processes are operative in idealization as well" (1952).

I think that there is a similarity between Eissler's amnesic patient who denies the trauma she suffered and the world that made that possible with Klein's notion of an omnipotent denial of the object and the frustrating experience. It seems to me that idealization and denial of painful facts were among the defences the parents of Fiona used during the time that she was so ill on the Unit. The staff got into this collusive procedure using omnipotence denial of the reality of what they could do and what could not be done for poor Fiona and her parents.

Summary

Cases like the one presented in this section act like an "emotional hurricane". They gather strength; the parents and staff get slowly weaker, more confused, desperate. I
try to use cases like this in the Staff Group in order to learn from our experience. I usually say that no doubt we will come across a similar case that will hit us in a somewhat similar way, and perhaps we could build some early warning systems.

Mother's frantic turning to psychotic defences, and long hopeless struggle drove everybody "mad" for a while. The feeling on the Unit at the time was that we were all struggling to hold on to some terra firma of common sense with great difficulty.

The mother was driven by a strong sense of guilt and failure, to use among other defences, idealization of her babies. She dressed them in beautiful dresses and put ribbons on their heads as if to show that they were as pretty as the dresses that she had made. She tried to deny the awful truth that they were damaged and that she had produced very ill babies.

There was a terrible sense of unreality on the Unit. Omnipotent statements were made by some members of staff that made me think about the psychotic defences of the staff, their own need to deny their inability to help and their own dread of damaged babies and depressed parents.

The infantile needs of the mother for an object that feels her feelings and is not separate from her was obvious, she "chose" some staff who really felt this "choice" as an honour. It had an enormous impact on the running of the Unit and I suspect that every now and again there are patients like that in a Neo-natal Unit as in any other unit (Main 1989).
I think this emotional process might have somewhat influenced medical decisions. It seemed that the need to deny facts might have contributed to the decision to keep the baby on the ventilator too long thus lengthening the time that parents and the staff were under terrible stress.

We all tried to make it better for her and we could not do much. I tried in my contact with the staff to point to the difficulties we faced in holding on to painful reality and our wish to deny it and to present a better version of it to ourselves and to the parents.

A month or so after Fiona's death, I was talking to one of the Unit's most experienced nurses. She had been on the Unit for 18 years! We calculated that she must have looked after 400 babies a year times 18 between 6500 to 7000 babies in her time. "What you need in a Unit like this" said Sister McCabe, "is not only a clever paediatrician but a wise one". I think she meant a doctor who is not too omnipotent. It seems to me that with the frantic turn to idealization and denial of awful truth the staff were facing a serious risk of losing touch with reality and at times actually lost touch. For a while omnipotent denial of truth was in control.

4.3 Second clinical example: The use of "implicit interpretation".

Introduction

In the following example I discuss the way I tried to help the nurses use their insight into the parents
difficulties by using what Menzies Lyth termed "implicit interpretation" (personal communication).

In good Staff Group meetings, when people are in tune with their own feelings, there is a degree of open and thoughtful understanding of the powerful projections that anxious parents engage in unconsciously. The difficulty parents have in trusting the Staff to look after their babies is made worse because the parent may feel he or she is also unable to look after the baby. They have produced an ill and/or premature infant which is seen by the parents sometimes as evidence of their inability to care for their infant. This worrying thought feeds into the difficulty of trusting the Staff. As if "goodness", the parents's, or the Staff's is felt to be too weak to withstand the powerful assault of "badness".(The infant's condition is talked about as an attack, a punishment).

The painful experience of the nurse at the receiving end of such projections is looked at in the following clinical case.

The usual way a nurse will deal with instances where she senses a degree of disturbed response, is to try to be factually truthful or reassuring. In this example a more direct emotional response to the data is suggested, where facts as well as anxieties are acknowledged.

The case

Luke was born after 29 weeks gestation. Mother reported feeling unwell after dinner, her water broke and she was rushed to hospital and her son was born that night.
Luke was the first baby of a married couple. Father was English, mother was Italian. Father was a fair rather plump young man, h is wife a pretty dark slim woman who according to her husband was obsessed with her figure and who did not eat as well as she should have during her pregnancy. I heard this at a Parents Group meeting. Father conveyed a sense of anger and resentment at his wife not looking after herself and therefore their baby.

The staff reported that father was very nervous and tearful. He took time off work and spent days in the Unit at his son's incubator. Luke was not well at all. He needed a lot of ventilation and underwent an emergency operation. The couple spent weeks in the Unit while Luke was fighting for his life. Father was much more distraught than mother who superficially was somewhat distant and aloof. I got to know them quite well over the weeks in the Parents Group but here I want to look at father's impact on the nurses who looked after Luke.

Staff meeting

The meeting took place a month after the case of Beverly Allitt the paediatric nurse who was found guilty of murdering 4 of her patients and had been headlines in all the papers.

Towards the end of a Staff meeting Ann said "You have to help me Amira, it really drives me mad. Mr. B is all the time in the room and he is so close to the incubator I sometimes cannot work and I have to leave the room. He is so suspicious I cannot work, I put a drip on, and he asked what was in the drip, and I told him and still he asked why was this liquid darker in the bag and paler in the
tube, I told him, trying to explain. He listened, and he went immediately to ask another nurse the same thing".

Shona said "He is like that with all the nurses. He asked me why we were giving his baby morphia, and was it not a dangerous drug? and I explained the therapeutic use we make of the drug for his baby, he listened but the next minute he asked the same question of another member of Staff." Ann said "He checks the drips and all the time asks questions I feel he does not trust me ". Shona said "It is the same with me and every body"

I said the factual scientific explanation which was given did not treat the suspicion and mistrust he felt about what was being done to his baby. Ann said "It is the Beverly Allitt case, I feel it is in his mind, I think he feels we are all like her".

I said it seemed to me very likely to be in all parents minds only they might not show it as clearly as Mr.B. I was listened to when I tried to say how difficult it was for Mr. B to trust the staff when he might feel he was let down by his wife, for not looking after the baby in her uterus or that his own masculinity was not enough to produce a healthy baby. He might have been trying to get rid of these painful feelings by thinking that it was the Staff that were unreliable.

Also it was not clear how he felt about having a premature baby? Was he sure of his ability to love the baby? or was he afraid of his own feelings? It was possible that he could not trust himself to care for the baby and keep him alive. He might be afraid that his own murderous feelings towards little Luke would get the better of him. I carried on "Do you think you could treat his anxiety by
saying to him something about it? Next time he is there and you sense that he is very suspicious say to him Mr. B it must be very tough for you to trust me with your baby's life?"

There was a pause for a few seconds then Ann said "I do not know". I said "You will have to treat the suspicion, not by talking facts, which you say does not help, but by referring to it directly". Shona said "I will try to talk to him, and at the change over I will tell the night staff what we have talked about because, they too, are driven crazy by Mr. B."

We then talked about the awful case of Beverly Allitt and how the nurses all feel soiled by it and how "contaminating" it was. They felt as if the parents all wonder about them, are they the same as the murderous nurse or different?

Discussion:

Mr. B who was suspicious of the staff who were caring for his premature and ill baby no doubt was having to struggle with his own death wishes towards his little and damaged baby. When Shona said she would pass the essence of our meeting on to the night staff I thought that she and maybe Ann too, were able to accept it and make some use of their own insight, would talk about it at night with colleagues and thus help create a sense of continuity so that people who were on "nights" could also benefit. I also noted that the level of openness and therefore trust that the Group had in me was fairly high, and was some evidence of the usefulness of the Staff Group meeting. I could of course speculate about the mistrust that existed between the staff and myself for instance.
What I thought about nurses in the week of the Beverly Allitt case and what they thought about me could no doubt be looked at. I feel that a more directly focused line of work needs to apply to the work of the Staff Group.

The following week when I was on the Unit one of the nurses who was in the intensive care room reported that the parents had had an argument..."In the past I would have pretended that nothing happened but after our last meeting I thought "No it is important" and I said something direct and the mother started crying and I felt that had I allowed her the space to be upset...she went out and they came back later a little bit less harassed." I thought that the arguments Mr and Mrs.B had might be linked to their sense that they had let each other down and had also let Luke down in having such a short pregnancy, which in a way led to his illness.

**The transference phenomena on the Unit**

Staff on the Neo-natal Unit are exposed all the time to projection from the parents and the babies and each other. The atmosphere is charged with powerful anxieties that stir up unconscious primitive defences.

The Staff are, of course, not seen most of the time as individuals but as a mixture of individual and transference figures. Freud writes "What are transferences? They are new editions or facsimiles of the impulses and phantasies which are aroused and made conscious during the progress of the analysis, but they have this peculiarity, which is characteristic for their species, that they replace some earlier person by the person of the physician. To put it in another way; a
whole series of psychological experiences are revived, not as belonging to the past, but as applying to the person of the physician at the present moment". (S.E.7)

The parents on the Unit go through the trauma of having premature and ill babies. They are usually very scared and upset. There is evidence from the work with the Parents Group of parents feeling very persecuted and guilty for producing premature babies. It often seems to me from what is said that unconsciously there is a strong phantasy that they are trying to protect their new born babies as well as their internal life-giving good object, from destructive powers.

It strikes me that there is sometimes a feeling in meetings of parents as if they feel that their murderousness towards their babies is too strong for their life giving goodness to keep the babies alive. This internal struggle gets spilled over into the relationship of a parent to the staff, particularly the nurse.

Paranoid suspicions are projected. There are frequently tense moments when a parent, overwhelmed with paranoid feelings, finds himself unable to trust an external good object, and treats the nursing staff with suspicion and anger, almost accusing a nurse of harming his baby. The projections are very painful and difficult to unpick. Not all the parents' complaints are projections. The more free the Unit becomes the more mistakes can be acknowledged.

Summary

Projections of painful feelings into the staff is common. The purpose of the discussion brought in this section is to try and trace the paranoid movement in a parent-staff
relationship in such a way as to enable the Staff to think and respond in a useful way. It seemed that the nurse had diagnosed a paranoid attitude in a father. It was possible to think about it and offer some intervention that might treat this difficult phenomenon head on rather than continuing with a scientifically correct but emotionally useless explanation.

It seems that the team was able to accommodate somewhat better, the paranoid suspicions that were projected by the parents into the staff. There is evidence of the nurses using the meeting to learn to treat the parents in a more open and helpful way.

This can be achieved at times when the degree of trust between me and Staff is high, when I am not seen in a paranoid way myself. It is possible to think that the Group felt very upset by the Beverly Allitt case. I was felt to trust them, and not think of them as the father did. Therefore there might have been some degree of gratitude and trust between me and the staff at that specific meeting which helped us get to the discussion of the parents paranoia and that of the staff.

There is evidence that interest in the psychological aspect of the work is growing on the Unit. After the last meeting Carmel said "I feel these meetings are difficult but I feel I am getting stronger." There is some more time and space in the team's work for the way the parents feel.
4.4 Third example, Changes in the defence systems of the Group, from cynical despair to some ability to mourn.

Introduction

The next two clinical examples of the work of the Staff Group will attempt to show modification of the Staff Group defensive positions. An example of some containment brings a shift from cynical despair towards an ability to mourn and projective identifications can be understood rather than acted upon. A change of "mood" in the whole unit can be detected.

The Staff Group work on the case of Mrs. S

On Friday as usual the staff that could be spared from ongoing work in the Unit and I met. There were 4 student neo-natal nurses, 2 qualified nurses and a Sister who chaired the meeting.

The staff nurses were busy making tea, and being very hospitable; someone had brought a cake in. I thought that was unusual, there were some brittle remarks until the Sister started the meeting and introduced me to the new students saying, "This is Amira and she sorts us all out". There was some laughter and and I thought I detected some mocking of me and perhaps of the group and its work. I said by way of introduction to the new students that the purpose of the meeting was for all of us to have a chance to think about the most difficult case or issue and that we spend a few minutes at the beginning of every
meeting coming to an agreement as to what is the most difficult or worrying thing we wish to discuss.

The group became serious and quiet, the Sister asked one student what she would like to discuss and she said Mrs. S. There was a murmur of agreement, people saying that it was an awful tragedy. I said that she would have to tell me the details of the case as I did not know them.

The student said "I sometimes think this is all a waste of time...the work here on the Unit, I, we worked so hard and all for nothing." The staff nurse continued "It is hard, you give everything you've got and it is useless". Clearly something very sad had happened.

The Sister with the help of the others told me about the case of Mrs. S. She was a 39 years old lecturer who had many fibroids in her uterus, was advised to have a hysterectomy but had then got married and had wanted to have a baby very much. She became pregnant and was allowed to continue with her pregnancy but knew that this was the only pregnancy she would have.

The twins she was carrying were born prematurely at 29 weeks gestation. They had to be separated, as the hospital where they were born did not have two intensive care cots available at the time. One baby and the mother came to Edgware, the other went to another hospital. Both were very ill...the poor father was travelling between the two hospitals. The baby at the other hospital died after three days and the one in Edgware had died the day before the meeting.

There was silence in the room when the student said "She, Mrs. S. is left with nothing...nothing...It was all a
waste of time and we worked so hard". People nodded.
Despair and hopelessness seemed to fill the room, some
cynical comments followed.

I felt that there was an agreement in the group. This was
the group's view; no one said anything to contradict it.

It seemed that the student was almost daring me to say
something different. What could be said that would make
it any different? They were dead and the mother had got
nothing. We had all worked for nothing. That was the fact.

The word nothing was very powerfully repeated. I felt sad
scared and alone. What "came out" as it were from my
mouth was: "I do not agree with the Group, you told me
that this woman wanted very much to have a baby, that
these were the only babies she will ever have. She went
through pregnancy, she gave birth to two boys and she had
two babies for a week, and then they died. That is all she
has, it is very little, we are not allowed to reduce it to
nothing. I think that we have to defend it and respect the
little she has."

I was listened to in silence and I added "Maybe one day
someone will ask her do you have any children? and she
will say, I had two boys for a week and then they died.
She was a mother of two babies for about a week. That is
all she has. We respect that and have to help her."

I found all this difficult to say but the atmosphere in
the room changed. It became more thoughtful as if some
awful depression was lifted and we all then felt like
having a cup of tea, the brittle comments did not come
back and for a while I thought that some mourning was taking place.

**Containing the Group's feelings**

It seemed to me that the group was using me, projecting into me loneliness, fear and despair. Work became "nothing" and pain became "nothing" in the face of the appalling tragedy. There was a risk that the Group would get into a manic flight from pain and "eat and drink and be merry " (the tea and cake). The team clearly liked Mrs. S and felt very bad at letting her down and guilty at their inability to save the baby that Mrs.S so wanted.

Manic reparation did not work and there was a sense of great failure. I think this was being got rid of into me and I found it terribly difficult to contain, make sense of, and return to the team in a somewhat modified and bearable state. The intervention was accepted. The Group was able to take it back and be more thoughtful, as if the Group's defences shifted somewhat from the paranoid to the more depressive. The failure was acknowledged somewhat in a less angry way, mourning was more available.

I wonder if unconsciously there was a strong maniacal wish to be able to perform a miracle, maybe to be able to do better than the other unit? I wonder also if there was anger at being confronted with the sense of human short comings. May be, I could have said " You seem almost to be trying to provoke me to see if I can make sense out of this appalling tragedy, to see if I can "contain" the feelings of hopelessness, meaningless, pain and fear". Such a formulation was not in my head ; I think it would have been too theoretical although it might have been
accurate. It seemed to me to be too remote and therefore of no use.

All I could do at the time was to say what I reported and to note some change in the atmosphere in the room.

When events are too painful, producing too much guilt and persecution there is a strong risk that the team will regress and use some very rigid primitive defences, as in the case described above. There the staff got confused and identified with the mother who was left with "nothing" and became threatened and identified with the dead baby who was reduced to "nothing."

The work of the Group, with my help as the object into which the projections were directed, seemed to prevent a slide into a brittle, persecutory, angry state. Some containment was achieved (Bion 1962), mourning became possible.

It seems to me that the team could be helped to openly talk about very painful events. There was a risk of a slide into illness. (Steiner; The Retreat from Truth to Omnipotence 1990).

Discussion:

Containment is one of Bion's most widely used concepts and was developed from Klein's concept of projective identification. The term projective identification is used widely to describe different processes; from projection of bad or hated parts of the self in a wish to enter, control and attack, to a need to communicate with the object an urgent powerful anxiety that is flooding the subject. Klein (1946) describes how the infant who needs to get rid
of bad parts of his self has the phantasy of projecting them together with bad excrement, into the mother or her breast so that she gets to become the bad self. "Much of the hatred against parts of the self is now directed towards the mother. This leads to a particular form of identification which establishes the prototype of an aggressive object-relation. I suggest for these processes the term projective identification. When projection is mainly derived from the infant's impulse to harm or to control the mother he feels her to be a persecutor. Good parts, felt as gifts given with love get projected too, thus leading to good object relation whereby the object is felt to be good or better having become endowed by the good parts of the subject projected into the object" (ibid).

Bion used this concept to develop a theory of thinking that had a profound influence on the theory and technique of Kleinian psycho-analysis.

Sandler (1987) describes the process of the containing ability of the mother's reverie as third stage projective identification that takes place not in phantasy only and is linked to Winnicott's "holding" function of the "good enough mother".

Bion states that "In its origin, communication is effected by realistic projective identification." He goes on to stress that communication is needed in order to achieve correlation and thus a sense of truth. Containment provides mental experience as essential as nourishment, "Realistic projective identification enables communication to take place, for this to occur the object has to have the will or ability to accept the projection and return them in a modified version so the subject can
introject them. If things go wrong and the tasks that the breakdown in the mother's reverie have left unfinished are imposed on the rudimentary consciouses...the rudimentary consciousness cannot carry the burden placed on it" (1961 ibid).

Summary

An example of containment in the Staff Group meeting is presented. A modified mood then prevailed, as a result of the work. Some mourning became possible, as the Group became somewhat separated from Mrs. S. An experience of containing that also implied containing the object that does the containing, thus strengthening the staff ability to contain, seemed to have taken place.

There were clear maniacal defences in operation, a cynical devaluation of work. Life and pain all became "nothing". It seemed that the staff could not face the facts and truth of this sad case, and reverted to an attempt to split and deny facts of life and death, becoming confused with Mrs. S who might have stood for an internal damaged reproachful object.

The work of containing the projection of the Group involved a high degree of psychic pain, as the attacks on life were acted out by the Group in the meeting. I felt that the intervention was acceptable and made a difference to the mood of the meeting. Cynical despair made way for an ability to mourn.
4.5 Fourth clinical example. Making the process of projective identification available for thought

Introduction

In the following clinical example I will show the working of splitting, projection and projective identification in the intense relationship between a nurse and a mother and the attempt to modify it in the Staff Group work.

The mother, a heroin addict, was on the Unit because her baby was going through a withdrawal. I believe that the harsh super-ego of the addict, (that might have driven her to become a drug addict) was split, projected into the nurse who was then totally taken over by this and proceeded "to be" as if possessed by a "foreign voice". This was clearly seen in the group meeting. There was a risk that the team would collude and a cold rejecting atmosphere be created. Some change became possible in the Staff Group setting where this powerful voice was confronted by a more reasonable approach of another sister.

There was a great risk that the team would get "infected" by a nurse who carries the harsh statement of the addict's super-ego and the harsh and cruel aspects of other parents. Also perhaps, she spoke on behalf of the baby, voicing feelings of being attacked and poisoned by what the mother has done.

The Staff Group meetings provided the setting for the reversing of this very dangerous, yet very common, process
of being sucked in, identified and then acting the rejecting cruel aspects of parents and staff.

Background to the case

The atmosphere on the Unit when it has to look after a baby of a drug addicted mother is particularly difficult. These cases are especially resented. Mothers are seen by some staff as cruel thoughtless figures who inflict on their babies what they cannot stand themselves i.e. detoxification. The baby, born "addicted" has to go through a withdrawal process that is painful, sometimes dangerous, even fatal. A baby who is "addicted" cries in a piercingly painful way, which is picked up immediately by anyone on the Unit as "different".

Staff try to be "nice" in order to cover up a sense of guilt for being so critical. The mother and father usually feel very guilty, and according to the staff "turn to drugs in order to get some relief from their guilt, they cry but come back the following year with another baby..."

Before the meeting, as usual, I went into the Unit and into Room 1 where the illiest babies are looked after. On this day a mother was holding a "big" full term infant in her arms. She looked haggard and held the baby very fondly. For a minute or two we were alone in the room. I said "It is good to see a mother in here, how is your baby?" She told me he was going through withdrawal, she was on heroin and Mogadon. At that moment a very pretty toddler and her father walked in. The toddler went to her mother for a second and than retreated and went to look in the other incubators. She looked restless and had the blank eyes of a deprived toddler looking for excitement.
She pulled at the wires, climbed dangerously on her mother as if she was a chair, came down, unavailable for any meaningful contact. I asked her what is her name she did not tell me; her father said Sharon.

Sharon had a toy lorry and I knelt down and pushed the lorry towards Sharon and she pushed it towards me. A nurse called Sue who was busy looking after the other baby in the room and gave me a stern look. I felt it as a criticism, perhaps we were making too much noise and I asked if Sharon would like to play with the toys in the toy corner. She agreed and went with her father to the corridor. I played with Sharon for a minute while father told me that his wife had been on heroin for 5 years. She was on a detox programme but went back on the drugs in the last two months of her pregnancy and that their son was very poorly. He sounded apologetic and embarrassed. We talked for a few minutes. I then left for the Staff Group meeting.

The Staff Group meeting

Present in the meeting were 2 Sisters, 3 nurses and 3 student nurses. Sue started the meeting and said "I want to talk about drug abusing mothers like the one in room 1. If she lived in the U.S.A. she would be regarded as a child abuser, she would be taken to prison and the child would be taken into care. I feel this country with its liberal attitudes is encouraging her to abuse. She will feel guilty no doubt" said Sue sarcastically. "Cry and then take some more heroin to make her feel better. She will be here again next year with a new baby who will have to go through the hell of withdrawal, that she herself is not prepared to go through and we will have to look after
it! I think she is a criminal, she should be in prison. She poisoned her own baby.

Sue was full of fury with the mother. She raised her voice and I thought that she appeared not to be her usual self. Eli told us that this drug addicted mother had been going through a detoxification programme whilst pregnant, but she had relapsed and injected heroin on the day she went into labour. "She had a urine test which proved she had abused a number of substances not only heroin. The baby is very poorly, he has had a number of fits and convulsions, he is very unwell." Sue said "He is the worst case I have ever had to treat, and when his mother asked me just before the meeting "is he all right?" I did not reassure her but told her that he was not all right, that he was very poorly but that we were all doing our best.

It seemed to me that Sue was not only being open with the mother but being very angry with her. The mother was clearly felt to be the bad poisonous figure who poisoned her own baby and came to Sue to save him.

Mary said "the mother talked to me when I was on nights and asked me are you angry with me? and I said to her do you want the truth or do you want to be comforted? and the mother said I want the truth, and I replied you are not giving your baby a chance".

I thought that Sue was cross with me "the liberal government that encourages the mother to do it again" because I was not severe with the patient's daughter Sharon or with her husband or herself. Sue is usually a very liberal nurse and her very bitter complaint sounded frank and out of character. It seemed that she had
absorbed into herself the harsh super-ego of the mother. It was an odd feeling as if we saw a nurse almost possessed.

Carmel agreed with Sue, Davey did not say anything. It seemed that Sue was talking on behalf of the Group and voicing a very critical angry point of view. I worried that this point of view was what the mother had to face on the Unit, and the only chance to confront it was there and then.

Sue said "Mother is making a mess and we have to clean up after her" with resentment, indignation and fury in her voice.

I asked how would putting the mother in jail as in the American system help the baby go through the awful withdrawal he is going through here? "Yes, it is true, it would not help" said Sue and added "I was not friendly to the mother I think she is a criminal".

I said "It is infuriating to have to nurse a baby that the mother has "poisoned" with heroin on the day he was born. Sue said "there should be a place, the government should provide a place where they can all go to dry out..." It was an angry meeting. I felt that Sue had convinced all the others or was speaking for them. At that moment, Jessica who is a Sister on the Unit but is also a community Neo-natal Sister who visits the mothers in their home after discharge said: "I would not take the baby away from her. She is a devoted mother, but a loser, she is a registered drug addict she needs £300 a week for her heroin she either steals or she is on the game, how else does she get the money for her drugs? She is a victim of a very aggressive and powerful sales technique, she has got
no chance." This was listened to in silence. The angry mood changed. I said "She is an addict, and therefore behaves like one, I regard her as sick and do not feel that punishing her for being ill will make her better or will help the baby. The team has to look after babies who did not get good care in their mother's womb. They have an interrupted pregnancy the team has to make it up. It causes deep feelings of anger and resentment. It is easy to feel angry with such a mother but I think some negative feelings occur towards the other mothers too, for "failing" to produce healthy babies.

Jessica told us more about this mother's home and pleaded with the Group for tolerance and restraint. The projection into the heroin addict of all the bad substances that are felt to be put into the babies by the mothers and staff, the anger with me for my "liberal attitude" was very clear but I felt that we had got as far as we could with Jessica arguing for sense and toleration. The meeting ended in a calmer mood, Jessica's voice taking the Group away from omnipotence into some contact with truth,(Steiner 1990) which is terribly painful.

I did not feel at that point in the life of the Group that an attempt to say to Sue "She, the mother, has made you carry her harsh superego that is shouting at her, that she is a criminal that has to be punished", would have served any useful purpose, although I thought that that was what in fact was happening. I felt encouraged by Jessica who managed to take the Group away from the violent reproaches into a more realistic way of thinking by telling the Group that "the mother is a victim herself". The Staff Group meeting is vital in that it
offers the setting to use the projection for understanding and modification.

Discussion

There is a risk that a massive acting out by the punitive structure of the combined super ego of the addict and of the staff can develop. A cold and judgemental atmosphere spreads, and it seems and feels as if the Unit has "caught" an illness i.e. it is identified with the super ego of a very ill drug addict. The resentment staff feel towards the other parents for having produced damaged babies, is directed towards the drug addicted mother, who is scapegoated, isolated and treated as a bad object into which the other parents and staff project their sense of guilt.

For example she was not invited to the Parents Group meeting of the Unit. The Sister, who, as a rule invites all the parents, said to me "I did not ask her to come, I thought that the other parents would attack her and that she would feel worse". From what I saw of this mother I shared the Sister's opinion that the addict invited criticism, I think the Sister was reporting an important anxiety about the weakness of the "good object" in herself or in me or in the team in dealing with the projections of badness into the drug addict.

The process started outside the Unit when the staff were informed that a drug addict was giving birth and that she had injected heroin on the day she went into labour. It seemed as if, the staff were injected emotionally by a form of poisonous substance, stimulating resentment and hate.
For Klein splitting and projection are among the most important defences, and part and parcel of object-relationships in the paranoid-schizoid position. In "Personification in the play of children" (1929) she shows how anxiety may lead to a splitting up of the super-ego into its component figures followed by the projection of particular figures in order to reduce anxiety. Splitting, is the ego's first defence against anxiety, rather than repression, which comes later.

Projection is a primitive defence described by Freud as working in paranoia where feelings or objects which the subject rejects, are then located by the subject, outside himself in another person or thing (1911). In 1915 in "The Unconscious" Freud describes phobic anxiety as the "projection of the instinctual threat into the outside reality".

In "Instincts and their Vicissitudes" (1915) Freud writes about the process of projection and introjection as the expression of oral instinct, the ego projects what is unpleasurable and introjects what is pleasurable.

I feel that the drug addicted mother projected her painful harsh super-ego into the nurse. She "locates it outside herself" in an attempt to rid herself of disturbing internal voices and images. Her addiction could be seen as an oral attempt to defend herself from an internal poisoning mother. She enacted this with her baby and almost got the Unit to do the same to her. She broke down and took heroin on the day the baby was due. It is possible to think of the heroin as an aid to splitting her acute paranoid and persecutory phantasies about herself and her baby.
Summary

A very charged situation occurred on the Unit when a baby born to a drug addicted mother went through the very painful and dangerous process of withdrawal. A parallel dangerous emotional process unfolded in the relation between the team and the heroin addicted mother.

The Staff Group meeting was the scene where the nurse who was as if "infected" by projective identification with the super ego of the addict and the team was calling for punitive revenge against the mother. The mother became the bad poisoning figure. She was "the bad mother" of the Unit who harms her baby. She was hated as the unconscious symbol of the other mothers who did not manage to have healthy babies.

The risk of some acting out by the team was very real. The mother was excluded from the Parents Group, rightly maybe, because the risk of a very super-egoish meeting was high.

The Staff Group meeting was the setting for a reality based voice of a member of staff who took the team from the road to super-egoish attitudes to some contact with reality.
This chapter addresses some of the emotional problems the Neo-natal team has to face. After some preliminary work reported in previous chapters I started a Staff Group with the aim of getting a chance to get a close look at the psychological anxieties and responses of the team.

The work on the Unit seems to have a different effect on nurses than on doctors. The burden of terribly hopeless cases that go on for months is enormous. The doctors, mainly the senior ones, who make life and death decisions carry a responsibility that drive them sometimes "mad". In cases that create crises, they can be seen to be detached from reality and trying omnipotently to control facts they cannot control. They are exposed to powerful pressures from terribly anxious parents who need to sometimes deny or flee reality and frantically turn to primitive defences.

The process of facing facts, patients' families' feelings and ones own feelings is looked at in Staff Group meetings as well as in many informal chance meetings.

As this is an intensive care Unit, it sometimes needs its own intensive emotional help. Some of the difficulties met with in the Unit are looked at in 4 clinical examples presented in this chapter. The use of denial and idealization that we all resort to is considered as a collusive omnipotent phenomena where the parents and the staff find it very hard to face very painful facts. I found myself acting as the "go between" the staff and the parents. I carried a sane message for the staff. The parents tell me they know the facts of life and death.
They free the staff to get off the omnipotent dead end. The impact on the team of such a case is very considerable (Main 1989).

If having a healthy baby is a form of narcissistic relief, having a premature and ill baby can be a profoundly disturbing psychological experience. The parents anxieties about the baby they have produced might also hide strong persecutory unconscious anxiety and phantasies about the damage or malfunction in their bodies, in their internal world, in their other babies and in their parental supportive figures.

Parents try to look for a reason why prematurity takes place; whose fault was it. Scientific factors, explanations put forward by the doctors or nurses are not enough of course in bringing down levels of guilt, fear, and depression.

It seems that the mother sometimes feels as if accused of letting down not only her baby but her internal good objects, it seems that a mother and father might feel that their good, life nurturing aspects are too weak and their sadistic aggressive aspects have got out of control.

The parents are then terrified that the "goodness" in the Unit will also not be strong enough to help and restore their infant to health. An acting out of this unconscious phantasy is at the core of one of the cases presented in this chapter (4.3). Father's paranoid phantasies were looked at in the Staff Group meeting. Some ideas of how to help were produced called "implicit interpretations" (Menzies Lyth). The notion in the meeting was that father's anxieties about what is being done to his very ill premature son might be linked to his unconscious ideas

-179-
about what was done to his infant in his wife's uterus. The very disturbing background to this case, the Beverly Allitt nurse who was headlines at the time, was looked at.

Staff get sucked into systems of powerful projections and unconscious processes of identifications, which gets acted out on the Unit. An example of such a process is looked at in Section 4.5 and work I did in confronting and trying to reverse this dangerous yet common process, making it conscious and available for thought, is looked at in the case of "The Bad Mother" (4.5). She, the heroin addict was seen as harming her baby, she was also hated as the symbol of mothers who are unable to produce complete and healthy babies and are unconsciously hated, despised and feared. The staff hostility to a drug addicted mother who harms her own baby by injecting heroin on the day of delivery is a vivid image of that.

The progress that has taken place on the Unit is that attitudes that were concealed are openly discussed. It seems that some common sense now prevails. The identification that could be used as a form of punitive acting out was talked and thought about at the Staff Group meeting which brought a change of mood to the meeting and from there to the Unit as a whole.

Staff often talk about "letting off steam here, in the meeting so as to be able to carry on in the Unit". A state of cynical despair could be seen in another meeting when the team was identified and confused with the dead babies of Mrs. S (4.4). There was a mood that nullified meaning, a risk that all would become "nothing". Both the work of saving life and the death of
babies, were felt to be under attack which reduced them into meaningless "nothing".

The Staff Group work with my help managed to change this sense of cold despair to a more alive terrible pain. A sense of an emotional shift is described, and the containing intervention is looked at. The team was able to "return to life" and feel sad for the tragedy of the patient. Some separateness was achieved, and with it compassion.

It is on healthy occasions when there is some mutual trust that the staff can share their emotional insight with me.

We can then try and formulate an intervention that might address the parents' emotional needs. I try and use the Staff Group meetings as learning occasions. We often talk about cases that might be similar that, might need this kind of intervention.

Issues of technique, and language in the Staff Group work have interested me all along. The Staff Group is not a therapy group; the people who attend are not the same people every time since they work a shift system. I feel I address painful issues of life and death meaningfully if I address the data in a way that encompasses my understanding of the data and the nurses insight. I try to use plain English.

There is some evidence that the work brings some change; a softening or melting of harsh super ego statements, mourning and separation become possible, negative feelings are stated and thought about.
The team can now undertake more difficult emotional tasks in relation to the babies and their families. It is also beginning to face and be aware of what the people who work on the Unit need, their inability to save life sometimes, going on too long with treatment, the need to be valued and loved by the families and by each other. These issues are looked at and the nature of the defences of the Unit seem to be changing. As the work goes on so the gains in insight are being tested. It does not seem to me that this kind of work can be finished. Like the painting of the Firth of Forth bridge, the team needs an on-going input if it is not to become "rusty" and collapse into mental ill health.
Chapter 5, The "Premature Parent"

5.1 Oedipal conflicts in parents of premature babies.

Introduction

In the normal developmental pattern of both men and women, pregnancy and birth can be viewed as the biological, as well as the psychological processes that demonstrate the reaching of adulthood. Pregnancy can be seen as the emotional process by which the mother and father ideally are getting ready to have a relationship with their baby.

On the other hand, the "premature parent" reaches parenthood suddenly, prematurely and sometimes with the added complications of sudden physical illness. The implications of these facts for the parent-infant relationship are explored below.

Parental confidence in his or her adulthood gets severely tested with the premature birth of a baby. Some parents whose babies come to the Unit reach this stage of becoming parents very traumatised. Feelings of terrible anxiety, a sense of failure and depression are common. There is a sense of a collapse or a breakdown of an adult personality into an earlier way of being, feeling and reacting.

The "premature parent" is the figure that I shall try to look at in this and the next chapter in an attempt to understand what types of anxieties and defences are likely to be present in people confronted with premature birth. What are the identificational processes that
invade their personalities, and their relationship to their infant. At the centre of normal maturational development is the resolution of the Oedipus Complex. I shall look briefly at this process. Klein's work on the early Oedipus conflicts and the early formation of the super ego, her expansion and development of Abrahams and Ferenczi's ideas appear to provide particularly useful windows into early processes seen on the Unit.

Pregnancy; and especially a first pregnancy, can be regarded by the "pregnant " couple and their families as a statement, the reaching by both the man and the woman of adulthood, a biological and psychological turning point. For this experience to be concluded successfully both partners must have navigated through milestones of development well enough. Simply put, the way the parents go through their Oedipal conflicts can reflect on their ability to survive the trauma of a premature birth.

Put in simplistic Kleinian terminology, the way the parents move through the Oedipal conflict in the depressive position, tolerating being separate from their objects and different from them, will indicate the way the parents will adapt to being parents of a premature baby (Britten, 1989).

I want to briefly look at the processes of maturation, then look at some clinical material from the work with parents in the Intensive Care baby Unit. I want to try and follow some cases and examine how a traumatic pregnancy is understood and experienced, and how it feeds into the conscious and unconscious relationship of the parent with the baby that was born from a disturbed or short pregnancy.
Bibring et al (1961) writes "for some women, pregnancy may be one of the most enriching stages of the life cycle, for when is one nearer to feeling like God than when creating a new life? In this way, for a young woman whose experience with her own mother has been "good enough" the temporary regression to a primary identification with the omnipotent, fertile, life-giving mother, as well as with herself as if she were her own child, is a pleasurable developmental phase in which further maturation and growth of the self may be achieved. For other women, the inevitable regression occasioned by pregnancy and motherhood may be a painful and frightening experience."
Pines says "First pregnancy affords a woman a further stage of identification rooted in a biological base. She enters upon the final stage of being like her own mother, a physiologically mature woman, impregnated by her sexual partner and in phantasy with her mother's powerful enough to create life herself"( I.J.P.A. 1982 63 311-18).

A lot has been written about the process of pregnancy and its psychological meaning for the woman and her partner. What interests me in this field is the factors that may help or hinder in the event of a traumatic break in the pregnancy when a premature birth takes place.

Both writers and many others agree that the resolution depends on infantile relationship with the mother, particularly the child's viewing his or her own mother's sexual and life giving roles. It seems that the centre stage in the struggle for independent adult life is hinged on the young child getting through the Oedipal conflict. Segal, in her introduction to the book "The Oedipus Complex Today," links Freud's work on the Oedipus complex with Klein's work on early primitive Oedipal complex and
Bion's work on the containing aspects of a mother's relation to her infant (p 5).

The Oedipus Complex and the formation of the Super-ego

According to Freud, the Oedipus Complex is a universal phenomenon. "It has justly been said that the Oedipus complex is the nuclear complex of the neurosis, and constitutes the essential part of its content. It represents the peak of infantile sexuality, which through its after-effects, exercises a decisive influence on the sexuality of adults. Every new arrival on this planet is faced with the task of mastering the Oedipus complex; anyone who fails to do so falls a victim to neurosis (Freud 1905).

The story of Oedipus "abused" (maybe he should be considered as one of the first physically abused children) and abandoned by his parents who as he grows up, kills his father and marries his mother, reflects the positive Oedipus complex. The complex is the map to emotional development of the child, through it we understand the child's love of the parent of the opposite sex, the death wish and hate of the parent of the same sex. This major discovery is at the heart of psycho-analytic thinking. It was discovered by Freud during his self analysis as we know from the letter to Fliess. It controls the choice of love-object, via object-cathexes and identifications. The structure of the personality is influenced by the complex and its decline in the latency period from lack of success (S.E.19) Another view is that "what brings about the destruction of the child's phallic genital organisation is the threat of castration. This possibility becomes believable by the sight of the female genitals, reinforced
by previous experiences of loss of the breast at weaning and the arrival of a sibling.

It is this threat of castration that pushes the little child to give up the object-cathexes and replace them by identifications. "The authority of the father or the parents is introjected into the ego, and there it forms the nucleus of the super-ego which takes over the severity of the father and perpetuates his prohibition against incest, and so secures the ego from the return of the libidinal object-cathexis" (S.E.19. ibid p176).

The super ego concept appears in a number of Freud's books. The feature that is relevant here is the idea Freud develops, that the boy gives up the Oedipal wishes and internalises the prohibitions of the conflict: the fear of castration is one of the results of this development (p177 S.E. 19).

A clinical example, Fear of castration in a father of a premature baby

A man in his early thirties who had a very premature and very ill baby on the Unit came to the parents support group. He told us briefly about his daughter's illness and his wife's terrible gynaecological history.

His wife had tried many times to have a baby. She had miscarried at least 7 times while with another partner. They now had a boy and the new baby, a girl was born after 25 weeks of pregnancy, as infection had set in because of medical intervention that had gone very wrong.
We listened, and then came the real "story". The man said smilingly that his wife wanted him to have "a cut", that is he explained, she wanted him to have a vasectomy.

It seemed the man felt, as if attacked. He came to the parents meeting without his wife as if he needed rescuing. We talked about contraception that might be right for him and his wife rather than a vasectomy.

I wondered if he felt that the birth of an ill premature baby was as if he had given her a "bad" unfinished baby, that she was very angry about: a product of a "bad penis" that he felt represented him, as a "bad man".

I also thought about his wife being mixed up in his mind with an internal angry and attacking parental figure. His goodness and ability to produce "healthy" "good" babies was severely doubted. That doubt and anxiety brought back a flood of castration fears. He came to the parent's group in order to find shelter from the attacking woman who was perhaps felt to be punishing him for what unconsciously he felt he had done to her. I can only speculate as I never saw the man again after that meeting, that the emotional storm he was in triggered the revival of Oedipal and super-ego anxieties.

He produced an ill premature baby that later died. I would have thought that he felt he had done something wrong i.e. had stolen the baby or given his wife a damaged baby that had come from a damaged, bad internal penis.

In the parents meeting we could only touch very superficially upon his worries not only about his family but about his worry about the sort of man he was.
The formation of the super-ego and the resolution of the Oedipus complex of a girl

In this area there are great differences between Freud's and Klein's views. According to Freud a girl's development follows a different path to that of the boy. "Her Oedipus complex culminates in a desire, which is long retained to receive a baby from her father as a gift—to bear him a child. One has an impression that the Oedipus complex is then gradually given up because this wish is never fulfilled. The two wishes to possess a penis and a child remain strongly cathexed in the unconscious and help to prepare the female creature for her later sexual role. The super-ego as an agency that is separated from the ego and controls it, is described in "The Ego and the Id". In "New Introductory Lectures" Freud states again his view that in the girl "The castration complex prepares for the Oedipus complex instead of destroying it: the girl is driven out of her attachment to her mother through the influence of her envy for the penis and she enters the Oedipus situation as though into a haven of refuge. In the absence of fear of castration the chief motive is lacking which leads boys to surmount the Oedipus complex".

Another view about the formation of the critical agency that acts like a judge and stimulates a sense of guilt is to be found in his paper "Mourning and Melancholia" (S.E.14). This agency or "conscience " that has among its functions the testing of reality, can become ill; it gets its power from the internal father that the child is identified with.

Klein has a different view. The Oedipal conflict that is activated by the frustrations that are the result of
weaning, starts according to her much earlier, i.e. at the end of the first year of life (1928).

Klein's important contribution to this area is the links she makes between the depressive position and the Oedipal conflict in her later papers. The Oedipal conflict is struggled with under the impact of feelings of ambivalence towards the parents. In her 1945 paper, the stress is on the reparative drive the infant is driven to in the depressive position, while struggling with ambivalent Oedipal impulses.

Clinical example

Most of the mothers I met, told me how guilty they felt about the prematurity or illness or both of their babies. All are looking for a reason for why it happened. It is often seen as a form of punishment, for what the mother did or should have done. If she had had an abortion, the prematurity is a punishment for that. It is often perceived as a God or fate that is taking revenge.

Mrs B was a very good-looking black woman from Nigeria. She told the parent support group meeting that she had triplets aged seven. She was very proud of the fact that she had carried them for a full term of pregnancy. The pregnancy, she told us was not a result of any fertility treatment. It was a spontaneous event. She was in the Unit because of her latest pregnancy. She had given birth to twins at only 25 weeks gestation. Her mood swung violently as she was talking to us: she was tearful for a few minutes, and then grinned happily when she said "I thought I could do anything after I had my triplets. Everyone looked at me at home. There is a special name in
our language which spells out the honour people have
towards the mother of twins or triplets. When I became
pregnant this time I was told I had twins and I though
that is easy I was told not to fly but I thought that I
had carried the triplets for the full term so what could
happen to twins? I never gave it a thought. When the pains
came I thought it was nothing... then the water broke but
it was so early I was going to ignore all this but my
sister insisted, so I came to hospital and they were born.
I did not want to look at them. I was so afraid and so
disappointed. They were so small. I just did not want to
know. The nurse picked one of them up to show me and that
made me push the next one out, I just was not interested,
I was so disappointed. I really do not know what to do
now, how will I manage? My husband is in New York now, how
will I do it on my own?" Then she said "They will be all
right I am sure of that ..." A minute later "It is a
punishment because I did have an abortion a few years ago.
It was only one baby so ..I aborted it. God is going to
punish me."

It was not clear if she was saying that she aborted the
single baby because it did not provide her with the
narcissistic glory that the triplets had brought. I could
not tell if she felt guilty because she was so
narcissistic or because she terminated a pregnancy, or
both.

Another young woman told the meeting that she was
couraged to abort by her family. She was a first year
student and when her family was told about her pregnancy
they were very angry. When she had a scan and discovered
that she had twins she made up her mind not to abort. "I
was going to do it if it was one baby, but two! I always
wanted twins.... but now Jacob is dead and I only have Levy so I have one after all."

I wondered about the guilt that Mrs B was talking about. Her twins were very premature and very ill and she was suggesting that this was a form of retribution brought about by her narcissistic satisfaction in producing three healthy babies, then aborting the pregnancy of the single baby.

Was she unconsciously taking on and triumphing over her internal parents' fertility, by feeling so much more fertile by having triplets? She later felt defeated, unsupported and all alone, as if her "triumphed over" parents, and the team standing for them, would not be willing to help such an arrogant murderous mother. Who did she feel she aborted when she aborted the single baby? Was it her mother's baby namely herself as a daughter that she was trying to destroy? She came by herself on a long flight to London feeling very alone, as if parent-less since the birth of the triplets and the abortion of her baby. How will she cope in a world felt to be "aborted" of help?

The sense of a world with no helpful figures was then projected into the Unit. She was not sure if she would be helped on the Unit. She became very depressed and withdrawn at the early birth of her twins, and at times became very high and mighty and difficult to help.

In his paper "Mourning and Melancholia" (1917 S.E.14) Freud describes a super-ego within the personality, acting like a judge stimulating a sense of guilt which might be unconscious in the case of the obsessional neurotic, "the essential thing, therefore, is not whether
the melancholic's distressing self-denigration is correct, in the sense that his self-criticism agrees with the opinion of other people. He has lost his self respect and he must have good reason for this...The analogy with mourning led us to conclude that he had suffered a loss in regard to an object; what he tells us points to a loss in regard to his ego" (p247 Ibid).

Mrs. B told us she felt alone, depressed and at times maniacal. It seemed she had lost a sense of trust in her internal parental figures and in the Unit staff. The attacked, fertile parents were no longer there to support her. The birth of the triplets, the abortion of the single baby and the birth of the premature twins could almost be seen as landmarks in her collapse into manic depressive state.

Summary

The meaning of normal and premature birth for the parents is considered.

My hypothesis, based on my work in the Unit is that premature birth can be experienced as a severe blow to the adult personality of the parent, revealing the primitive pre-Oedipal lines of the personality structure. A very primitive and persecutory super-ego is presented, tormenting both parents in the examples brought in this section. Their feelings about their internal parents' cruelty and indifference get projected into the team in the Unit. The father became extremely angry with the team. His baby's death exposed him not only to acute pain about his loss but also to paranoid anxieties about his identity
as a sexual adult man. Mrs B continued to feel very much alone, uncared for and very depressed.

It seems to me that a premature baby is sometimes experienced as an external super-ego, extremely demanding and frightening and causing mothers to suffer from attacks of melancholia with its relentless demanding internal objects viewed as ideally "good". The mothers, in their attempts to separate the bad, damaged, dying phantasmied baby from the real live ill one, are often ill with despair, depression or confusion that is fed by the fear that the split will not hold, and that the live baby is not safe from the internal and external bad, hating, attacking objects.
5.2 Acute ambivalence in a mother of a very premature and ill baby.

Introduction

In the case presented here we see the ambivalence towards the baby and the Unit that propels this mother into an episode of depressive illness. The baby, who was very ill, became confused with the serious illness that Kate had suffered from the 4th month of her pregnancy. It seems that thoughts and feelings about the baby and mother's illness needed to be avoided using instead a number of defensive strategies.

The Clinical Background

After the parents' group meeting on the Unit on Monday, Kate said to me in the corridor that she wanted to see me on her own. I arranged for us meet the following week at a time she was on the Unit visiting her daughter.

Tania, Kate's daughter, had been born 7 weeks earlier. Two weeks after giving birth mother was discharged from hospital, (having been an in-patient for a several weeks before the birth because of illness.) After being discharged Kate came to see her baby every day, staying for most of the day on the Unit.

Tania had been born after an emergency Caesarean operation. Mother had had very high blood pressure early on in her pregnancy. She had told the parents group meeting the previous week, that the doctor told her that her condition was unusual in that her blood pressure
became very high very early on in the pregnancy. When she was about 23 weeks pregnant she had been hospitalised and at 28 weeks had undergone an emergency Caesarean operation. After Tania's birth she was told by the expert she could have kidney problems and might not be able to have any more children. These highly disturbing facts were related in a very factual way, with no feelings or facial expression, as if she was talking about someone else, or as if it was of no great importance, in a crowded parents meeting.

Kate was 30 years old. She is married and had been trying to have a baby for 5 years. Tania was her first baby. She said that her husband's contract would finish in January and he would have to work on his own, there was an implication that he would be unemployed. Kate's father had high blood pressure, and his wife said that he had gone on holiday because he could not bear to come to see little Tania so tiny with tubes everywhere. It seemed, that he felt that his blood pressure was the cause of his granddaughter's problems, as well as his daughter's. I shall discuss the grandparents' feelings later on in this chapter, but here I just want to point out that this was their first and only grandchild at the time, and they appeared to be very caring and warm people, but seemed to collapse almost under the sense of Tania and Kate's ill health, and their sense of guilt about this.

Some of Julian's feelings (Kate's husband) of rivalry and inadequacy came up in the group when he talked about his brother and his little nephew. His nephew said when he had heard that Julian had a daughter who was very small and ill "it does not matter". He said he felt himself
somewhat small and disabled, as if having an ill baby had produced a sense of failure.

Meeting with Kate

In our meeting Kate said that she wanted to see me because she was very depressed. She did not want to do anything or see anybody. People phoned and she did not want to talk to them. Friends asked her to go out and she did not want to. This was not like her, as she used to go out and always be active. Now she felt very tearful and empty. She was talking in a cut off, flat way as if reporting about someone else. As I had never met her before she became a patient on the Unit, I can only say that she made me wonder about earlier depression, as she seemed to me to have been cut off before. I asked if she had ever been depressed before. She replied that she thought she had been as teenager and had felt that her sister had been the preferred successful one, but then said the way she felt now is far worse. I said that she was telling me that she felt different and did not recognise herself and that, for a start worried her. She agreed, in a flat sort of way and said "I just want to come and be with Tania. I cannot sleep. I get up at two or three and I just lie there. I went to my G P. She gave me sleeping tablets and it was fine I could sleep but then I did not want to do anything."I asked what she thought or dreamt about at that time in the night? Kate said "I do not think or dream, I just drift and I see Tania and the cot".

I asked "Is she the same size as she is now?" Kate replied "Yes, exactly as she is now". I said "It sounds as if in your mind you are still in the Unit and not at home in bed." Kate thought a minute and agreed. I said that I thought that she felt she had to be with her baby,
because after all she should still be in her womb. Kate agreed, saying "Yes, maybe."

I suggested that it might be very difficult to go home and leave the baby behind, as after all she was really only at 35 weeks gestation, and she still should be inside, almost part of Kate. Kate said "I do not feel guilty, we are going for a weekend away this week." At this my heart sunk and I wondered if the symptoms were there replacing feelings. How would she deal with going on holiday? Would she become more depressed?

She had a fairly emotionless face when she added that the doctors would be doing some tests on her kidneys in five weeks time, about three months after she had given birth. It seemed, I said, that she "heard" the doctor saying not that he needed more tests, but "you will not have more babies". Kate said to me "Yes, I just want to look after Tania. Today when I came in I was told she had had her first bath, the first bath in her life. I wanted to do it." I said that I would have felt very angry and asked if she had she told Margaret, the nurse assistant who had bathed Tania? She said that she had done. I said that there was no excuse, sometimes they had to feed the baby if the baby was hungry and the mother was not there but they could have waited for the bath for an hour. I said "I am really sorry".

I thought that not only Margaret but the whole Unit is a womb substitute, that she felt robbed of her baby by a Unit that helps, but highlights her inadequate uterus and her phantasy that she is an inadequate mother. Kate said "It is difficult to be cross when they give you so much". At the end of the hour we agreed to meet again the following week. Kate later cancelled that meeting. When I
saw her again on the Unit in the incubator room she reassured me that she was feeling fine, that her weekend was fine that Tania was fine... well no she was back on oxygen and had a cold but... she was fine. The climate of reassurance was firmly re-established.

I see this pattern very often, namely the mother reassuring the staff, reassuring the mother, and a circular system is established where no worries are admitted or are exposed and looked at.

Discussion

What does this premature baby mean to this mother?

Kate developed very high blood pressure unusually early in her pregnancy, after 16 weeks. It meant that she had to be carefully monitored and hospitalised at 23 weeks of her pregnancy. Tania was delivered five weeks later. The pregnancy was endangering both baby's and mother's life. There was a risk of Kate having a heart attack. It seemed that the thought about a monster object that was attacking her life was so painful that she could not bring herself to think it. From this monster she tried perhaps to flee when she went away on her short weekend. She would not wish to bath that baby.

She developed a depressive illness, could not sleep or do anything. At night she had a phantasy, an illusion, that she was back with her baby in the Unit. She needed to be with her baby, denying the fact that she had been born and was in the Unit separated from her mother, and being looked after by "strangers", thus denying the paranoid
anxieties about what the baby/pregnancy was doing to her body, and what sort of baby had she produced.

Projection

She heard the doctor saying that she would not be able to have any more babies. I feel that he was perceived both as a rude and cruel doctor as well as an internal super-egoish father who disqualified her from motherhood.

She went on a weekend holiday leaving the baby in the Unit as if in an attempt to get away from this impossible situation, as well as to get away from her thoughts and feelings about herself and her infant. Before she went on her short holiday she asked to see me and told me, and let me feel how cut off she was from her feelings. She cancelled our second meeting while reassuring me on her return that all was well when it was painfully not the case. I felt useless and not needed by Kate. It seems to me that what Kate felt in the Unit needed to be expelled into me.

Her baby became ill again and she was cut off from her worries. The threat of "no more babies!" was projected into the doctor then introjected as an external threat. Later on I learned some more about Kate's difficult relationship with her mother that might have fed into this anxiety. This is looked at in the following chapter.
The dynamic of reassurance

In his paper "The Dynamics of Reassurance" (IJPA 1993 p275-285) Feldman shows the use of this mechanism of reassurance which is called into play when a particular anxiety-laden phantasy becomes central and disturbs the patient's psychic equilibrium, "the patient then strives to restore the state that he has lost, either in phantasy or by attempting to draw the analyst into a familiar enactment" (p284).

Kate was not my patient, nevertheless, I think some enactment took place that might have brought some momentary reassurance. I was asked to see her, then after showing me her anxiety she "dismissed me". I feel disqualified and useless as perhaps she felt, demoted by Margaret who bathed her baby, by the Unit which took over and looked after her baby, and by the doctor who said that she could have no more babies, while Kate could not provide a life nurturing-environment for her baby.

I wonder if this interaction with me brought some relief to Kate in her terrible predicament. For a while she was not the rejected mother, (rejected by the staff who are felt to take over) who produced an ill baby who made her dangerously ill. What am I for her? I am seen at the start as a possible source of help in her state of depression, I am later dismissed. She told me some time later about her sister who, she felt, was much more successful and a loved figure in the family. It is tempting to think about an attempt to get me involved in this crisis in her life: make me into the unloved and useless Kate while she becomes the healthy sister. Does she stop being a mother of a very ill baby or a woman who

-201-
has very high blood pressure, while I contain some of her burden?

She was caught in a terrible storm of ambivalence: the Unit was life giving as well as depriving of a sense of being an adequate mother. The baby was wanted and feared; resented and loved. I think the fear of the baby dying and the fear of being killed by the pregnancy, namely the baby, was too painful to think about. There was some notion that all her future babies had been destroyed.

Not only was she afraid of the fate of Tania, she was also afraid of the contents of her mind. She was afraid of her own feelings and disturbing thoughts.

Conflict that leads to confusional states

I think that the conflict of seeing the baby as a murdering monster as well as a very ill frail baby, and seeing the Unit as life-saving, as well as robbing her of her role as the mother of the baby, drove her to her illness. It seems likely to have a long term influence on her unfolding relationship with her baby.

The view of the object as both highly dangerous and endangered leads to strong paranoid anxiety as Klein puts it in her paper "Psychogenesis of Manic-Depressive states," "paranoid anxiety that the objects sadistically destroyed, should themselves be a source of poison and danger inside the subject's body causes him in spite of the vehemence of his oral sadistic onslaughts, at the same time to be profoundly mistrustful of the objects while yet incorporating them"(p264).
It seems to me that a very ill baby is felt to be a danger to the mother as well as a producer of a sense of guilt and that Kate was struggling to distinguish and control her terrifying phantasies.

Klein states "In my experience there is furthermore, a deep anxiety as to the dangers which await the object inside the ego. It cannot be safely maintained there, as the inside is felt to be a dangerous and poisonous place in which the loved object would perish. Here we see one of the situations which I described above, as being fundamental of the loss of the loved object... the situation, namely when the ego becomes fully identified with its good internalized objects, and at the same time becomes aware of its own incapacity to protect and preserve them against the internalized persecuting objects and the id".

Confusional state

I think that there was a failure of splitting and keeping separate good and bad objects, libidinal and destructive feelings which led to a painful confusional state and a loss of identity in Kate. The good baby and the dangerously murderous baby are confused with Kate's internal good and bad objects, and further confused with her own internal world. Painful doubts occurred as to whether she could produce a healthy baby as her inside was felt to be a dangerous place where baby/pregnancy caused an increase in her blood pressure to a very dangerous level. Herbert Rosenfeld in his paper "Note on the Psychopathology of Confusional States in Chronic Schizophrenias" (1950) develops Klein's concept of splitting and projection and states, "under certain external and internal conditions when aggressive impulses
temporarily predominate, states may arise in which love and hate impulses and good and bad objects cannot be kept apart and are thus felt to be mixed up or confused. These infantile states of confusion are states of disintegration and are related to the confusional schizophrenic states of the adult which I am describing in this paper. The confusional state is associated with extreme anxiety, because when libidinal and destructive impulses become confused, the destructive impulses seem to threaten to destroy the libidinal impulses. Consequently the whole self is in danger of being destroyed. The only escape from this danger lies in the ability to differentiate again between love and hate. If normal differentiation cannot be achieved, splitting mechanisms become reinforced".

Manic denial

Klein in the paper referred to above (p216) writes about the manic defence against paranoid and depressive anxieties using the processes of denial, primarily the denial of psychic truth and the contempt of psychic pain. She writes "the manic subject denies the different forms of anxiety... his denial relates not merely to the impulses of the id but to his own concern for the object's safety... this disparagement of the objects importance and the contempt for it is I think, a specific characteristic of mania and enables the ego to effect that partial detachment which we observe side by side with its hunger for objects"(ibid p278-279).

It seems to me that Kate's weekend break from looking after her daughter was achieved by a manic denial of her own anxiety about her daughter and about herself. I experienced the statement that she was going to be away as a somewhat cold superior rejecting gesture. As if to
demonstrate that feelings or sick babies did not matter, nor did an arranged meeting with me, all were treated in the same spirit of manic denial.

A lot of mothers who have had one premature baby say openly that they will not try for another baby. One of the unconscious reasons for such a statement is surely the phantasy that mother's inside is not a safe place for a good baby to grow in and a baby might poison and damage mother's inside, thus leading to what Klein terms "the loss of the loved object... In a situation of acute and powerful anxiety the differentiated good and bad objects are under threat of getting confused again with this, feelings of hate and love too, can be confused and misdirected... The ego feels itself constantly menaced in its possession of internalized good objects. It is full of anxiety lest such objects should die. Both in children and adults suffering from depression, I have discovered the dread of harbouring dying or dead objects especially the parents inside one and an identification of the ego with objects in this condition the processes which subsequently become clear as the loss of the loved object are determined by the subject's sense of failure" (ibid p 266).

Summary:

A clinical contact with a mother of a very premature baby was examined and the mother's anxieties were discussed. Her strong ambivalent feelings towards her baby and the Unit were considered as the factors that might have led her towards her depressive illness. It seemed that she became too disturbed by the thoughts and feelings provoked by the her serious illness caused by her pregnancy, a way
out for a while, was to be cut off from all that was in her mind.

It seemed that great difficulties in differentiating between reality and phantasy existed in the mother's mind presented above. The new-born baby was endowed with phantastic qualities, when the reality of his being was very unclear and certainty of his life not secure. Nor was the connection between the mother's illness during her pregnancy and her baby made clear. The process of differentiation was fraught as the sense of failure to give life, became fused with the sense of failure to preserve life. The Unit's work was ambivalently accepted. The Unit was felt to be doing a good job in preserving the life of the infant but at the same time reducing the mother's sense of her maternality. The internal unconscious anxieties about the nature of the mother's internal world were "mixed up" with her concern about her physical well-being. Omnipotence of parents was fused with denial. A devaluing of feelings was unfolding in this case and I was unable to change this.
5.3 Pathological identification with the unit as a "Narcissistic organisation"

Introduction

With the new arrangements in the NHS and the development of purchasers and providers, a new source of stress is unfolding in the Unit. The service is felt, at times, to be more involved with budgets than with the well-being of patients and their families. This pressure sometimes influences clinical judgements in a critical and destructive way. When this takes place, a mother can become identified with a perception of the Unit as a "narcissistic organisation" and begins to distance herself from her own love and commitment to her baby. The mother I will present, seemed to have suffered a breakdown and become cold, omnipotent and disinterested. One of the less sensitive nurses pronounced "she is much better, she has got used to the situation". I took this comment to mean that this mother had stopped protesting and had become identified with the bad, rejecting and abandoning Unit. From the nurse's comment it seemed that the nurse too, had stopped protesting and had adjusted and become reconciled. Below I bring some facts about the new structure of the Unit and follow one case to demonstrate the outcome.

Some of the impacts of budgetary considerations on clinical practice

For the past few years the Neo-natal Unit at Edgware has had the status of a sub-regional unit. It has the manpower and equipment to offer intensive care for up to four babies born outside the borough of Barnet.
With the reorganisation in the NHS and the introduction of the split between the purchasers and providers, Health authorities now pay the Paediatric Directorate a fee for this service. At the moment the fee is £8000, namely every baby who gets intensive care from outside Barnet comes with a cheque of £8000.

The cost of keeping a baby in intensive care and the support services that this demands is £1000 per day. There is therefore an obvious pressure on the system to discharge a baby as early as possible, in order to make a profit or at least limit the financial loss. If a baby is in the Unit one day, the Directorate makes a profit of £7000, however if a baby stays for weeks the Unit loses money.

I became familiar with these facts from discussions with the Consultant and the Nursing Manager of the Unit, and I was also repeatedly told to by all the other members of staff on the Unit.

Some staff responses to the new structure

With these facts came the anxiety expressed by many people of having to make money in order to secure their jobs. A sense of insecurity began to be noticed, as well as a sense that the Unit's work makes money for the Paediatrics Directorate which overall is losing money.

These are new facts that are part of everyday discussion, and provoke many different thoughts that come up in informal and formal staff meetings. One nurse said in one of the meeting with me "I like the discipline that came with the new rules. I know I used not to think about how much nappies cost or cotton wool and now I think about
it". She welcomed the discipline, but others thought that it only serves to waste the money saved somewhere else (on new and more administrators is the most popular thought). The staff were invited to a party in a pub which created a very cynical response. "I thought we are supposed to save money, and anyway we have parties on the Unit so that even if you are on duty you get a drink but this, it cost a fortune and only the people off duty can go" (from staff meeting in June 1992). The sense of "them" and "us" became very strong." They show this Unit as a good unit, to all sorts of visitors, but they want to cut staff. How can we be good if they take away the more experienced people and bring in unqualified people?"

The conflict between financial and clinical issues and its emotional aftermath came alive for me in the case of the Cohen twins. The terrible shame was that no one gained. There were just losers. The service was and still is more expensive and far less good.

The clinical case of the Cohen twins

Mr and Mrs Cohen were a very religious couple were in their early thirties and had tried, unsuccessfully for 6 years to have a child. After infertility treatment at the Royal Free Hospital Mrs Cohen became pregnant with twins. When she was 29 weeks pregnant and on a visit to some relatives she started labour and was rushed to the nearest hospital which happened to be Edgware General Hospital. She gave birth to two boys.

On a Monday I was told by a nurse that they were born over the weekend by Caesarean operation. All went well and the parents were thrilled to have at last succeeded in having two healthy, tiny babies. Although mother had had
an operation she was up and trying to breast-feed the babies. She was very pleased indeed that they were able to feed although they were so small. I went to congratulate mother who was in a state of euphoria she was so happy and thought the Unit wonderful and that everybody was very helpful and the doctors were so clever. She showed me her book of prayers covered in white leather, she was praying very hard.

The conflict between budgetary and clinical considerations

On the following Wednesday when the twins were 10 days old, before the staff meeting with me, the Nursing Officer met me and said that she was very sorry that she could not join us but we should talk about the Cohens. That morning she had had a most difficult meeting with Mrs Cohen: she was so upset and cried so much. The Nursing Officer was feeling very sorry for her. In the meeting of the Nursing Officer had told the mother that she would be transferred with her twins at the end of the week, to the Royal Free Hospital. The twins were doing well, they were breathing on their own and not needing any oxygen, she would be nearer her own home which would enable her to visit as she was going to be discharged herself at the end of the week.

Mrs Cohen collapses

Mrs Cohen on hearing this burst out crying and was very distressed and frightened. It took a good hour to comfort her. "I am used to dealing with distressed parents who have very sick babies or even lose a child but this was really bad" said the Nursing Officer. "It was like the other case from the Royal Free that we tried to move and they too were so upset they thought they would expose us
in the media and the press, call all sorts of influential people, we let them stay and they did not want to go home". We talked about the powerful and painful dependency that parents develop towards the Unit that is seen as saving their baby's life. It seems that when the discharge is thought about, it is necessary to take on board these anxieties of parents, or else we can expect psychological difficulties.

It is clear, I pointed out that the new financial demands result in new sources of stress for the families. Before the reorganisationsuch small babies would not have been transferred to another Unit. It surely does not make sense clinically, as the babies still need intensive care, and the move causes the parents terrible anxiety by transferring them to an unknown unit. The irony of course, is that no money is saved by the NHS: the babies still need the expensive treatment, and there is the extra cost of the transfer in a special ambulance with a Sister and a Doctor. It seems that there is only a paper or accounting saving for the Barnet Unit. I said all this, feeling that there was a real dangerof erosion of clinical standards. We then talked some more about Mrs Cohen and the Nursing Officer repeatedly told me how distressed and how unconsolable Mrs Cohen was.

The Nursing Officer was a very experienced and had been running the Unit for 10 years. She clearly was very moved by the obvious distress of Mrs Cohen and was concerned for her and for the twins. It seems to me that the new way of nursing premature babies, as is demonstrated in this case, is very possibly a source of guilt in the staff, who have not identified with the new ideals. (It is interesting to note that the Nursing Officer who tried to support Mrs Cohen had, a few months later, to leave. She fell, hurt
her knee and was forced to leave her post a year later. She seemed to have been the only member of staff to have suffered a break-down at least partly as a result of the new arrangement.

In her distress Mrs Cohen begged to be allowed to stay: she had health insurance, she could pay, her husband could pay. She did not know the unit at the other hospital, she was afraid of the move so soon. They all knew her here, were so good and caring for her... could she not stay? Hearing all this the Nursing Officer promised she could stay until the end of the week but after that she would have to go to the other unit.

The impact on the Unit

This case can of course be looked at from the staff point of view. Although I am looking at the breakdown of the mother in identification with her perception of the "new culture of the Unit" I think it is important also to note the impact this new approach has on the way the Unit staff now conduct their work. It is central of course to the work of the medical management of cases but it filters through to the nursing staff as seen in this case.

I asked the Nursing Officer if the pressure was mainly financial and she said "well it is both, you see, if we keep them here we cannot have our own babies, but also there is the thing with the money". I felt very worried about the situation. I think that the Unit is becoming a place were issues of profit could become more important than clinical ones. It seems to me that the unconscious guilt is dealt with by rationalisation and splitting: the
care of "our babies" becomes a way of justifying bad clinical practice.

The new meaning of an old term; What does the term "my baby" mean?

The use by nurses of the term "my baby" or "my mother" is very common on the Unit, and when asked how a baby becomes "my baby" the usual answer is that it is if the nurse brought the baby to the Unit from the labour ward or is looking after him for days. It is a term that illustrates the relationship of the nurse to her patients.

I noticed a new use of the old term. Now "our babies" used by the Nursing Officer did not refer, as in the past, to the patients her Unit, but to the babies whose parents are living in Barnet. This is the way the doctors talk, although there is also a muddle and the same term is used to denote a "patient" on the Unit, or the potential population from where patients are referred. I think that the new use of the term is an attempt to pacify a sense of unconscious guilt. I also think that there is a risk of an unconscious identification with a non-caring cynical "management" that is seen as worshipping only money. In an intensive care baby unit I think this can be very dangerous indeed. The new way of functioning is illustrated by the new use of the term "our babies".

Mrs Cohen becomes worse

At the subsequent staff meeting I was told by one of the nurses "Mrs Cohen is O.K. She was telling me when she came in to feed her twins that she will soon give that
up, that she will get a nanny like every one else and will go back to work".

I worried that Mrs Cohen was experiencing the transfer to the other hospital as evidence that the Unit does not care about her and her babies, and that she is identifying herself with a rejecting non-caring Unit. I worried that she had started to reject the babies she so wished for and who had been, only a few days ago, a powerful spring of joy.

I went to have a word with Mrs Cohen after the meeting but she would not talk to me. The curtains were closed around her bed. She was praying and said that she did not want to talk to anybody. (Was she trying to make me feel some of the rejection she was struggling with herself?)

In her paper "On the theory of anxiety and guilt" (1948) Klein traces the root of anxiety to "unconscious fear of annihilation of life". She states "if we try to visualize in concrete form the primary anxiety the fear of annihilation, we must remember the helplessness of the infant in face of internal and external dangers. I suggest that the primary danger situation arising from the activity of the death instinct within is felt by him as an overwhelming attack, a persecution".

On leaving Mrs Cohen I felt that she could well be identified with the helplessness of her tiny babies feeling persecuted by external factors, the Unit telling her she would be moved, as well as internal factors, her sterility and premature birth, that might well have been experienced as an attack on her maternal identity by a hostile internal mother figure. I thought that she experienced the transfer of her babies to another unit as
a persecutory attack that reinforced her internal turmoil which she tried to deal with by manic defences, namely praying non-stop, an attempt, I felt to summon help of the good godly father, in the face of assailing external and internal tormentors. When this attempt failed, in order to escape from the overwhelming burden of guilt and despair, Mrs Cohen regressed to a more paranoid state of mind and started to distance herself from her babies and talked about going back to work and leaving her babies in the care of a nanny.

It seemed that caring made her come close to anxiety and guilt. It was unbearable and she became cold and detached. Following a period of idealising the Unit, the transfer reinforces a process of devaluing caring for her babies. I think it devalues caring as such. She introjects what is felt to be an omnipotent cold narcissistic Unit and in a state of identification with that object is unable to care for her babies. The caring ego was too weak in the face of the internal as well as the external bad objects.

Discussion of Mrs Cohen's case

It seemed to me that a process of breakdown of care can be seen in this case. Mrs Cohen became identified with the pathological aspects of the Unit. She could not care for her children under the impact of the feelings that the Unit did not care. The transfer was felt to spell cynical carelessness and she identified with this.

Identification

What interested me was the identification of Mrs Cohen with the uncaring cold Unit and its impact on her abilities to mother. I am not suggesting that the Unit
alone is responsible for what took place in this case. There are no doubt other important individual factors that are part of this mother's biography. I do however, believe that the Unit is felt to be a "parental space" that has an important impact on a mother when she is at a most vulnerable state.

Freud states that identification, the earliest emotional human link that is known to psychoanalysis, plays a major part in a child's relationship to both parents in the shaping of the Oedipus complex (1921).

Klein (1955) writes about identification by projection, introjection and internalisation. She shows that a good object is secured internally by strong positive feelings towards it. A well established good relation to an internal object to will allow according to Klein an inflowing and out-flowing of libido with no sense of depletion. The ego in fact is enriched by the process. In his paper "Psychopathology of Narcissism" (1964) Rosenfeld writes "identification is an important factor in narcissistic object relations. It may take place by introjection, or by projection, when the object is omnipotently incorporated the self becomes so identified with the incorporated object, that all separate identity, or any boundary, between self and object is denied."

In his paper "Narcissistic organisation, projective identification, and the formation of the Identificate" (IJPA 1985 66, 201-13) Sohn writes "To me it appears that in the narcissistic organisation, an identification by projective identification has taken place: the process of identification starts the narcissistic organisation: that is to say by becoming the object, which is then felt to be within the possession of the self. It is this that
produces the feeling which we call omnipotence, or which enhances the intrinsic omnipotence that is present in all of us and accounts for the strong bland arrogance of these patients, who can then think, do, be and exert all the influences of the original object. It has all the chameleonic satisfaction of being a new object and wishes to stay that way. It is however, done, destructively and can never be used constructively - the destruction being to the state of the ego, and to the object which is consequently devalued."

It seemed to me that the breakdown in care and love seen in Mrs Cohen was established in her absorbing into herself and becoming unseparated from the "narcissistic organisation " of care in the Unit. Care and concern became devalued and subjugated to cold disregard to patient's feelings.

It is a process that has a potentially damaging impact on the relationship between Mrs Cohen and her babies. It also has a very destructive influence on staff who feel guilty at abusing the care of patients, which leads to a sense of unconscious guilt and the development of a cold cynical mood on the Unit, which implies that unconsciously the Unit feels itself to be overwhelmed by destructive bad ideas and objects.

I went to see the Nursing Officer and shared my worry about Mrs Cohen rejecting the twins and how damaging this start to a difficult relationship could be. I was also worried as to what this sort of policy would do to people who work on the unit and how guilty they must feel and what they would do with their guilt.
Why should the money factor be allowed to override clinical judgment, surely there is a real risk of financial factors overruling clinical ones? Will the Unit not admit very ill babies for these considerations? Is it here to make as much money as possible? Is there a sense of success if it makes money?

All these questions I put to the Nursing Officer, and at a later date, to the Medical Director of the Paediatric team in a meeting I asked for, in order to tell him about some of my research findings to date.

Is there a pressure not only to balance the budget but also to actually make money? The answer was "Yes! We are now under pressure not only balance the budget but also to make money. If the Unit can bring in more money it will plug some other unit's needs. I said to the director that I was worried about the lowering of standards as we were now in a different world with different priorities and this put strong pressure on the staff. He said "No, we should judge each case for its needs". I shared my thinking with the Consultant of the Unit and I think that exposing this way of functioning in formal meetings and informal ones helped somewhat redress the balance. I feel staff are under tremendous pressure to "convert" to a new way of being and working.

Summary

A breakdown of a mother of very tiny twins was looked at. She became profoundly disturbed when told that her twins at the age of 31 weeks gestation would be moved to another unit. She trusted and idealised the Unit that had saved her babies lives and found the move too great a threat to cope with. The move was in part a result of the new
arrangement of care in the NHS Mrs Cohen had a narcissistic breakdown: she became identified with her perception and experience of the Unit as a cold uncaring omnipotent place where care and concern is second to bureaucratic dictates. She decided to give up care of her babies.

I suggest that a rejection of ill, frail babies by their parents is all too common a situation. It could well be said that Mrs Cohen was so high when the twins were born after so many years of sterility that a cold rejection of them was possible. Parents need a strong model of a caring team to identify with and counter the tormenting inner doubts they battle with. This is an account where the Unit failed and the result was inevitable.
5.4 Some thoughts on guilt in a mother of a dead baby

Introduction

Over the years of my involvement in the Unit I came to know a number of women whose babies had died. Some in uterus; one who was diagnosed as having "Edward syndrome" died 6 hours after birth; others lost their babies after months of hospitalisation. There is a wide range of reaction to this: one an extreme was that of a father who said to staff to dispose of the baby as they wish, throw the body away and leave him alone to intense and terrible pain.

Most of the mothers told staff members and me that they felt guilty. In meetings, staff reported comments of both parents feeling guilty.

The experience made me think about issues of unconscious and conscious guilt and the possible confusion in the mind of the mother who lost a baby about what had been lost and its possible meaning to her.

The fact of giving birth to a damaged infant can stir up persecutory anxiety about the strength of the aggressive impulses being out of control and the weakness of the reparative ones. These thoughts are so disturbing that mothers might try and avoid thinking all together for a while. I want to bring brief clinical material from a meeting I had with one woman who became very disturbed after her baby died, and look at some of the psychoanalytical writings on the topic of guilt. The
subject is important. Parents suffer a great deal, and staff report that they are unable to help.

The clinical picture

The Paediatrician asked if I could help and see Jackie, a mother of an "Edward syndrome" baby. He was worried about her. He told me that she had had a baby that died 6 hours after he was born. She blamed herself for the death. She came with her mother to see me the following week.

Jackie was a plump, blonde 19 year old. She told me that she had had a baby last May, that he had lived only 6 hours. Since then she had been unable to sleep because she had been having recurring nightmares. She was afraid to go to sleep because of the nightmares. She then proceeded to tell her nightmare.

Jackie's nightmare

In her dream she is near a grave and it is a baby's grave. She cannot see the baby but his arm is sticking out of the grave and it is pulling her into the grave. In the other part of the nightmare the baby is broken into two parts and her mother is involved but she does not know how.

I asked if she had any thoughts about what the dream was about. Jackie said, "I think I feel guilty because I told the doctors that I agreed to their turning the ventilator off". I said "you feel that you are responsible for Sam's death?" She answered "yes". Eli, the Neo-natal Sister who was with me said, "we never turn the ventilator off if there is a good heartbeat". To that Jackie said, "yes, his colour was going". She told us that the scan she had had at 22 weeks of her pregnancy had shown gross abnormalities
and that she had been told he would not live. "The doctor said that what he had was not compatible with life". She was offered a termination which she turned down.

I said, "It seems to me that you feel guilty that you were not able to save him, and keep him alive". Jackie agreed. She added that her boyfriend left her when he was told about the condition of the baby. She had not heard from him since and she did not want to. Jackie's mother then said, "He could not face the fact that his child was not perfect". Jackie carried her pregnancy to full term. Labour took 65 hours and was very difficult. Her baby was a boy. She named him Sam. He was born alive and was put on a ventilator for 6 hours and after that it was switched off and he died.

Eli asked if Jackie could talk about this at work and Jackie said "No, there are some women who are pregnant at the office and they treat me as if nothing happened. I have one good friend, I can talk to her, but I watch TV all night because I cannot take the nightmares. It is the guilt". I asked about suicidal thoughts and Jackie told us that she "flipped" last Friday. She had been at a party, she does not remember it but was told that for two hours she was shouting that she wanted to die, and she was not even drunk. No one at work wanted to know or hear about the baby. I asked if she felt that people avoid her as if her tragedy is some catching illness? Her mother said "yes, absolutely". I then told Jackie about our parents' group and wondered if she would like to come. I said "I do not know if you will sleep tonight but I would like you to come back and meet the others". Jackie was not sure but her mother said that they would come. They both stayed and took part in the parents' group. On the way out of the
Unit I met them and I was ignored as if we had not spent the evening listening to her painful account.

Discussion

It seemed from what Jackie said that she felt guilty. I tried to help her think, by saying that guilt has to do with doing something wrong, or not doing something that should have been done, and that I could not see at this stage what it was that she was guilty of. Jackie said "I agreed to turn the ventilator off. Maybe if I hadn't he would still be alive."

It was quite plain that she did not believe all the medical information that was given to her about her pregnancy not being viable, and about the baby not being able to live. With hindsight, I feel that perhaps it was a mistake to ventilate such a baby. It might be seen on reflection that the omnipotence of the doctors was also contributing to her omnipotent doubt. An Edward syndrome baby has no chance, so should he have been ventilated, or should he have been allowed to die at birth?

From some comments of the staff, it seemed that it had all been done in order to help Jackie. But I cannot help wondering if, in fact, it was a mistake.

It was clear that facts had no impact on her feelings. It seemed that the thought that hers was a non-living baby was too unbearable. She then turned against herself: her suicidal thoughts were murderous impulses towards herself. It was her unconscious that produced the nightmare that kept her awake for nearly a year. It seemed to me that she was feeling that she had lost the hope of producing a healthy baby. In her dream her mother was involved. I
wondered if the internal mother was felt to be killing Jackie's motherliness. It also seemed that she needed to get rid of any thinking or the part of her that thinks or remembers.

I was wiped out from her memory on our meeting outside the Unit as an object who is attempting to understand or help. It might be that she was looking for an omnipotent figure that might reverse or wipe out what had taken place in her life. I thought I let her down just like the medical team did. They too could not reverse her tragic facts.

Guilt

Freud (1916) states that the feeling of unconscious guilt comes before the crime: the latter is its results, these deeds were above all done in order to be forbidden. Children behave badly in order to be punished.

In the process of dealing with Oedipal desires Freud stated that we find guilt as the expression of tension between ego and super-ego, resulting from aggressive phantasies against the father.

In her paper "The theory of anxiety and guilt" (1948) Klein, using Freud's discovery of the death instinct, writes: "thus in my view the danger arises from the inner working of the death instinct which is the first cause of anxiety. Since the struggle between the life and death instincts persists throughout life this source of anxiety is never eliminated and enters as a perpetual fact into all anxiety situations".

Using the idea that projections and interjections start from birth she states that the infant projects its own
sadism onto the internal parental figures that then are perceived as devouring dangerous figures. The ego is felt to contain devoured and devouring objects. Thus the super-ego is built up from the devouring breast (mother) to which is added the devouring penis (father). These cruel and dangerous internal figures become the representatives of the death instinct.

Klein separates depressive guilt, in which the ego is concerned for the object, from persecutory guilt, in which the ego is fighting for its survival while feeling under threat of the devouring internal objects.

Jackie's guilt

Jackie said she felt guilty. She was tormented by a nightmare in which the dead baby's arm is pulling her into its grave. She added that the baby was broken into two parts and that her mother was involved. Needless to say she was not in analysis where associations are gathered and transference is checked, but it does seem to me that the internal good object was felt to be destroyed with the statement that her baby would not live. Her boyfriend left her, her mother said because he could not tolerate having a less than perfect baby. Jackie was rejected by the boyfriend and by a part of herself that attacked her mercilessly. Jackie I feel, was overwhelmed by a sense of having a damaged inside and a damaged internal world. It seems to me that she was persecuted by the tragedy. She was not able believe that she could become a mother. I wonder if she felt that her aggressive feelings towards her internal objects got out of control, and the Edward syndrome baby was the result, symbolising the evidence of her destructive impulses for all to see. The foetus was confused with internal objects, if she was to have a live
baby she might feel that her good internal objects function well; as it was her ego was overwhelmed. Her sense of guilt seems to me, to be very much linked to a primitive anxiety of her ego being under threat of annihilation. The suicidal thoughts seemed to be an attempt to flee from this unrelenting internal situation.

Guilt and omnipotence

I wonder if being pregnant was felt to be a taking over of her mother's place unconsciously. That echo of unresolved Oedipal conflict deprives Jackie in her unconscious phantasy of a helpful supportive mother. Her omnipotence let her down. She was pushed back to a paranoid state of mind.

She did not come to our next parents' meeting. It seems that it was not possible for her to feel that there was anyone who would want to listen to her. She had reported that no one listened to her at work.

What she was looking for was a manic repair that would wipe out the painful facts, turn the clock back to the time before her pregnancy.

Discussion

A recurring statement I hear from mothers who have babies on the Unit is that they feel "guilty". Some clinical material is presented. Some attempt at trying to understand this statement is put forward. The link between guilt and anxiety is looked at and it seems to me that the mothers are possibly referring to a sense of persecution implying that they are not only mourning the loss of their babies, or the loss of the phantasied "good and healthy"
babies, but also unconsciously feeling that their aggressive impulses are threatening their internal good objects. I suggest that the dead or ill baby is confused with aggressive destructive impulses and objects that are felt to be out of control. Having a real baby is confused with a phantasied internal object.

Jackie was afraid to go to sleep, and was afraid she would lose her mind.

Other mothers told the nursing staff of similar difficulties. They were afraid of what they might do to their babies, and also of what they might think and feel about their babies. Some mothers were afraid they would kill their babies. It sometimes seemed that the baby, its illness, and its prematurity were felt to attack the mother's phantasy about herself and her abilities to give birth to a healthy normal infant.

Mothers were afraid that they could turn aggressively against their babies or their partner, who had "given" them such a damaged and damaging infant.

I often think about such hidden violence in the relationship between the couple and its long-term impact on the stability of families of premature babies.

5.5 Discussion of chapter 5.

Winnicott in his paper "Primary Maternal Pre-occupation" (1956) described the mental state of a new full-term mother. According to him she is in a special frame of mind which he calls "Primary Maternal Preoccupation". He thinks that not enough has been done to understand the mother who is in a state of withdrawal from the outside world for a
few weeks, she is totally involved with her baby. The mother, if there is no baby, would be seen as having a schizoid episode, (p301-312 the Collected Papers). He writes "The woman must be healthy in order both to develop this state and to recover from it as the infant releases her. If the infant should die, the mother's state suddenly shows up as illness, the mother takes this risk" (302).

A pre-term birth cuts short this process described by Winnicott. The mother gives birth before all this development can take place. Some births, like the one described in this chapter take place 12 weeks early. It is not uncommon to have babies born after only 25 weeks gestation, 15 weeks before they should be born. The whole of the third trimester is missing.

We know quite a lot about the phenomenon of physical prematurity on the baby. Neo-natologists can treat the lungs and the heart of the premature baby by various machines that take over and bring him to maturity.

We know something about the physical impact on the mother's body the Obstetricians monitor and help. We do not know much about the emotional impact of prematurity on the mother. She is a premature mother. The process described by Winnicott that should have taken place does not have time to occur. What takes place instead is what I tried to look at in this chapter. The impact of the "double prematurity" (that of the baby and the mother) is the area I think that needs further study.

In this chapter I looked at three mothers and their emotional struggles. I think feelings of acute ambivalence and depression looked at in Section 2 are quite common together with manic denial, idealisation and strong mood
swings and a strong sense of persecution and guilt, seen in Sections 3 and 4.

I think that the notion which prevails in the general public, that giving birth is a normal process and that the woman who gives birth is not a patient is simply not the case in a Neo-natal Unit.

Some mothers have major emergency operations, some are very ill with high blood pressure or are diabetics. Yet their needs as psychological patients is collusively denied by staff and the mothers themselves. It is as if the focus of who needs help has been settled on the baby. The notion that both mother and baby are ill, and at times the whole family is upset and worried, is almost ignored.

Here I want to finish by speculating about the possible impact of the double prematurity on the mother-baby relationship. I wonder if the sense of incompleteness that is around a premature birth like the one described in this chapter gets projected into the baby, if there is a sense of unreality, a sense that the premature parent feels he or she is a fraudulent parent. It is possible that the prematurity of the infant and the parent are in the way of the infant introjective and projective process. Does the sense of prematurity then become greater, thus undermining normal development. Both baby and mother have to navigate through a difficult adjustment in order to find the way for normal development of the mother-infant relationship.

This chapter started with the notion that pregnancy and birth can be seen as the expression of the reaching of adulthood of the couple. For this stage of development to be reached safely the Oedipal conflict has to be navigated, more or less normally, via the depressive
position. What happens to the "premature parent?" I am suggesting that may be the parents do not go thorough the depressive position in a disturbed short pregnancy. Therefore separating reality and phantasy is very difficult. The birth of an ill premature baby can be an emotional trauma for both man and woman that pulls them back into a pre-Oedipal way of being, into the paranoid position of feelings, where the severe internal super-ego gets mixed up with the authoritative figures who are heard, as if nullifying the parents sexual maturity (Sections 2 and 3 in this chapter).

There is not much of an "emotional intensive care" structure that is built into the team that can deal effectively with the parents difficulties. I think it is very much needed. In the next chapter I look at the work on this issue in the parents' support group with the help of the staff.

If both baby and parent are premature and feel premature this could affect the processes of projections and introjections that are at the core of the mother-infant relationship.

There are studies (Chapter 1) that tell us that very premature babies, when they reach school age, do not achieve the academic standard that their I.Q. entitles them to. I wonder if the interaction between a premature infant and a premature parent could contribute to this difficulty. If the infant identifies and introjects a parent who might feel insecure or fraudulent in his or her function as a parent, that would affect the infant developing the sense of himself and his introjected objects.
Chapter 6, The work of the parents' support group.

6.1 Starting a parents' support group

Introduction

There are at least two patients when there is a premature birth: the baby and the mother. One of them, the mother, receives far worse care than the baby, as a patient. Father is almost invisible. The staff are busy saving the lives of the infants. "So get on with it!" is the message the parents can get, and on the whole they do "get on with it."

One is used to the ideas advocated by lots of women, the Natural Childbirth Trust and many midwives, that having a baby is a normal process, therefore a mother is not a patient, she, in giving birth, is doing something that does not turn her into an ill dependent person. This is true in normal delivery.

However that is not the case in a Neo-natal Unit. There, a lot of mothers are ill. A number have serious clinical conditions, for example many mothers have dangerously high blood pressure or are diabetics. Some go into early labour with no warning or illness, others undergo emergency major operations. Yet they on the whole are treated as if they are well. They are discharged five days after their operations and are treated and behave as if nothing much has happened to them.
The woman might have had a major trauma: sudden bleeding, sudden birth, but this is almost denied by her and the staff. I wonder what are the dynamic forces behind this. Is it because the team needs to ignore these disturbing facts and can only cope with the fragility of the infant? Has it to do with splitting, namely the mother is someone else's "baby". The Unit's concern is with the infant. This "selflessness" ignoring mother's experience, is seen in the parents group. Mothers will talk about the baby's state of health, but not often about themselves unless asked. Is the culture of the Maternity Unit to state that having a baby is a normal process therefore there is hardly any differences between a well woman and a sick one?

One of my assumptions was that the team colludes with the parents in a manic denial of the reality of the parents' and particularly the mother's state of health. It is easy to speculate that a mother who gave birth to what she might feel is a damaged and incomplete baby, is struggling with a concrete figure equated in her mind (Segal 1958) with an internal damaged and damaging object that is feared and therefore ignored, in an attempt to flee from it. This flight might be a reflection of the mother's phantasy about what is wrong with her "inside", the physical and emotional internal space.

I was told of a mother who had an emergency Caesarean operation on a Monday and was in a shopping centre three days later, and of another who went to buy for nappies two days after her Caesarean operation, on the way home from the hospital. I often see mothers up and dressed looking anxiously into the incubator some 10 hours after their operation. I feel convinced that were they men or were the procedure not linked to a premature baby they...
would have been treated and would have allowed themselves to be treated as what they were, i.e., patients.

(I would like to try and see in the next project, if a mother who had a full-term baby after a Caesarean operation is treated in a subtly different way to the mother who had a premature baby, and if they are treated differently again from people who have an abdominal operation).

In this chapter, I shall try to show one attempt to change the attitude to parents, which implied a major change in the team's perception of its task. The issue of how emotionally well the parents are straight after premature birth comes up again and again in the work with the staff. It seems there is an almost breathtakingly high expectation of how parents can respond, parents who just after a Caesarean birth have lost a baby or have to be informed that their baby is very ill or might have long term problems.

I am often told by the parents "the doctor was saying things to me about the baby but I was not able to listen, I could not take it in, so I just sat there blocking it all off."

I think the simple truth that the parents, particularly mother, might not be well, needs emphasising as it is sometimes ignored both by parents and staff.

The primary task

The view of the primary task of the Neo-natal Unit was that it was to save its babies' lives. We came later to think of this as a somewhat incomplete definition. In other words, the primary task changed from being anchored
in the more primitive paranoid position with strong idealisation and denial to a more depressive perception, linked more to a realistic view of what the team and parents can do. This process reached a stage at which I thought the team could support a parents' group. I am not implying that there were no swings towards the more paranoid view occasionally. Below I want to look at clinical and theoretical issues that surround the work with the parents' group. The support that the staff gave, and is giving to this venture implied a degree of development and change that took hold in the unconscious and conscious mind of the team.

Discussion

Taking parents' feelings seriously as an important task for the Unit staff to involve itself with, implies a change in the team's perception of its primary task (Rice, 1958). For such a change to have a chance to be taken on there needs to be a change in the team defence systems (Jaques, 1955, Menzies Lyth 1959). Some evidence from my work with the staff demonstrated a move away from the primitive defences of splitting and idealisation to a more realistic view of the Unit and its staff.

It becomes an "anti-task" process if the Unit takes over and provides good care for the babies but reduces the motivation and dedication of the parents by unconsciously making them feel redundant or ill equipped.

In her paper "Staff support systems: task and anti-task in adolescent institutions" (1979) Menzies Lyth writes about the task and anti-task in institutions. She says that social systems are usually chosen for primary task work but members of institutions are also likely to seek
satisfaction of personal needs that are anti-task. "Members of institutions try to establish a social system that also acts as a defence against anxiety, both personal anxiety and that evoked by institutional membership" (p229).

In his classical paper "The dynamic of organisational change" Jaques put forward the idea that change in organisations is impossible to achieve without first working to modify the unconscious anxieties embedded in the social structure. Jaques then moves to state that the change that would enable progress to take place has to be seen not in the behaviour level alone, which he compares to the level of symptoms receding in individual psychotherapy, but at the phantasy level.

Starting a parents' support group in the Neo-natal Unit was a change. It was a practical change that was built on a change in the defensive system of the Unit as well as in its perception of its primary task (Rice 1958). In practice it needed, and still needs, the commitment and involvement for a long time, of the nursing and medical staff of the Unit. People were, and still are, doing this in their own time. (They came when not working), if their shift did not coincide with the time of the parents' group meetings, and they then got time off in lieu. The project was and is supported by the members of staff and the management of the Unit.) It became part of my job on the Unit to start and run the parents' group with the help of the nursing staff.

It is only lately that nursing staff who work on the parents' group are put on the shift that coincides with
their need to be on the Unit on a Monday evening for the parents group.

At the core of this work is an attempt to look and listening and understanding the emotional ordeal of parents whose babies are very premature and ill. It seemed to me that the conditions for such an undertaking stood a chance if there was some evidence that the defensive structure of the staff had moved somewhat from a "paranoid " to a more depressive position, at the phantasy level (Jaques). This in turn would imply that the team felt listened to and somewhat supported.

Putting this in a less theoretical way: the Unit staff needed to be functioning in a way that could be called realistically-based, not needing reassurance that they were wonderful and what they did was always perfect. When I felt that people were somewhat less defensive and that the staff could "live" in the real world, tolerate the facts of work on the Unit, having their own need for denial and idealistion understood and their ability to tolerate somewhat the sadness that this work entails strengthened, (shown in some detail in Chapter 4), then I could start a parents' group involving the staff in a more demanding relationship with the parents' feelings.

Summary

The parents' emotional conditions are often wholly denied by both parents and staff, Some thoughts about this phenomenon are put forward. The Unit team had to move into a somewhat different mode of working in order to support this new task of working with the parents. It implied a change in the defence system of the team. The team's ability to tolerate the parents' emotional conditions
fluctuated all the time with external pressure and internal resources interacting. It was a task that needed the psychotherapeutic support of the Therapist of the Unit and the nursing and medical staff working together.

6.2 The work of the parents' support group.

Introduction

In Chapter 5 I looked at some features of the emotional reality I came across in meetings with the parents of premature and ill babies on the Unit. I came across depression, persecution, manic denial, idealisation and abnormal guilt. I am suggesting that both mothers and fathers find having a pre-term ill baby a disturbing fact not only because of their normal anxieties for the well being of their babies, but also, it seems that the baby became confused with phantasies about their internal bad or damaged objects.

It sometimes seems that the adult personality of the parent is undermined by powerful unconscious pre-Oedipal phantasies that attach themselves to the baby's condition. The short "unfinished" pregnancy must also reduce some of the emotional work that normally goes into the foundation of the parent-infant relationship. It seems to me that it is possible to think that the depressive position is sometimes missed in the premature pregnancy with some long term results that are well worth exploring in the future.

I think that "the baby" is felt at times to be unconsciously orally or anally produced and orally and anally attacked, being referred to at times as a "scrap", "a rat", "mangled". It seems the parents
sometimes feel that their aggression got out of control and "the evidence" is there in front of their eyes. The baby's condition is felt unconsciously to be evidence of their aggression, overwhelming their reparative creative instincts.

They often feel guilty, or responsible for what has taken place. They withdraw into an identification with narcissistic uncaring figures, or become depressed, paranoid and persecuted.

It is a fact that the seriousness of the family's emotional needs has to be taken up as a central task of the service the Neo-natal Unit has to provide if it is in the business of giving the babies the best chance of a healthy outcome.

The work of a parents' support group

There are a number of reasons for a parents' support group on the Unit. First, to deal with the need to deny the facts of the parents' and baby's situation.

In meetings with almost all the parents the response to an inquiry about themselves, was "it was terrible last night or last week but all is well now." This could be said during the most worrying emergencies. Superficially there are no worried parents or sick babies on the Unit at present, but there were anxious parents and sick babies in the past. In Section 5 of this chapter I try to show this data and how I deal with it in the group.
Denial

This is the usual phenomenon I meet at the beginning of most parents meetings and at informal meetings by the incubators: parents spend the first few minutes reassuring each other and me about how well everything is (with themselves and their babies).

A father came with two very ill babies in an ambulance. It was one of the most awful cases I came across. There had been serious neglect and delay. Both babies had serious brain injuries and the mother was very sick indeed at another hospital where birth had taken place after a long labour. I thought the man, a very big tall man, was going to faint and crash into the incubators. That meant that I felt he was "aware" of the seriousness of the situation of his babies and wife, and that he would at any second crash out of this awful awareness into oblivion of being unconscious. He instead was reassuring himself and me that all is now alright. It made me think about the Israeli Prime Minister, Mr. Rabin who, after he had been shot told his driver on the way to the hospital where he died an hour later, that he was alright.

In a number of papers (S.E.19) Freud links denial of reality to psychosis. In the paper "The Loss of Reality in Neurosis and Psychosis" he states "I have recently indicated as one of the features which differentiate a neurosis from a psychosis the fact that in a neurosis the ego, its dependence on reality, suppresses a piece of the id (of instinctual life), whereas in a psychosis this same ego, in the service of the id, withdraws from a piece of reality... In a psychosis, a loss of reality would necessarily be present, whereas in a neurosis, it would seem, this loss would be avoided" (p 183). Put in another
way Freud states "In neurosis a piece of reality is avoided by a sort of flight, whereas in psychosis it is remodelled. Or we might say in psychosis, the initial flight is succeeded by an active phase of remodelling in neurosis, the initial obedience is succeeded by a deferred attempt at flight" (p 185).

What was taking place in the Unit was a swing from neurosis to psychosis and back again. Difficult news was avoided and remodelled. This is looked at below in the first clinical example. Denial is a major subject of psycho-analytic research: Freud, "Analysis of a Phobia in a Five year-old Boy" (1909); "Formulations on the Two Principles of Mental Functioning" SE 12 (1911); "Instincts and Their Vicissitudes" SE 14 (1915); "Group Psychology and the Analysis of the Ego" SE 18 (1921); "Inhibition, Symptoms and Anxiety" SE 20 (1926); A Freud, "The Ego and the Mechanisms of Defence" (1936). The Kleinian view is that in the paranoid-schizoid position powerful primitive anxieties threaten the ego and lead to the use of primitive defences of splitting, idealisation and denial of external reality (Klein, A Contribution to the Psychogenesis of Manic-depressive states, 1935).

The parents in the Neo-natal Unit, in my view, are persecuted by the painful external reality that ushers in the use of denial. Sometimes they are afraid that their babies will not survive and will die. The tall father of the very ill twins was trying to run away from the fear that he would lose his whole family. I thought that he would faint and thus opt out of reality, but he used a different system, he talked non-stop about how all was now well. He too was using Freud's formulation remodelling the facts and thus avoiding them. Was he psychotic at that moment in time? I do not know. He was running away from
terror. Maybe we all do at such moments. In a group of parents it is possible to experience and see that all parents need to reassure themselves (Feldman 1993) and flee from what has taken place in their lives very recently. Sometimes we see the manic flight from reality in full swing. Sometimes we see mania offered by one parent as a solution to the group "come fly with me, lets go to..." in the words of a famous Sinatra song. At others total denial is offered. The group then tries to collude.

Providing a time and space to acknowledge both facts and feeling.

I was often surprised at the facts that were mentioned in the meetings, their nature and the intense need people had of sharing them with the group.

For example, a mother of a very premature baby girl needed to tell me that her sister's baby son that had been born only three months before and was full term, had died two hours after his birth. She cried and talked about her sister's baby and wondered what chance her baby had. She had waited a long while for the meeting to start. It was clearly of importance. She had arranged for her sister to baby-sit the other children.

In the staff meeting after the parents group I wondered what was she needed from us. The Sister who chaired the parents' meeting said that the Neo-natal team had not been aware of the facts, although the dead baby had been born in the hospital and had been talked about, as the tragedy was so unusual. The relationship between this mother and the mother of the dead baby was not known to the team. I was not going to see this woman again and so
the only chance of some understanding of her anxiety was at the meeting. I felt that I, or the meeting, had been called upon to make sense, to reassure, (Feldman, 1993), to acknowledge that the mother felt terribly worried. Did she have the "right" to or a chance of a living baby, if her sister's baby had died?

The meeting had a role as the place where painful facts were stated. We heard about abortions, miscarriages, serious illnesses and death of close relations and their historical links to the birth of the new baby: "this took place a month or a year before the birth" etc.

Elkan (1981) thinks that narrating the story of birth gives the mother or father a chance to make sense of their experience as well as to gain acknowledgment of their emotions. McFadyen thinks it helps in the process of healing and relationship-making, (1994).

The findings of these workers seem to be close to mine. I think the group was helpful for people in making some links between the way they felt about themselves as parents, their babies, and other members in their families. It also seemed to help the Unit, as the group provided some containing experience for the parents, and helped the staff to be more available to the parents.

Feelings that were stirred up were also faced. It often seemed as if facts and feelings that had never been faced were exposed. I wondered about fathers who came and talked about their feelings and started with the statement: "I never talk or think about this... I usually do the decorating or go out for a run." Couples sometimes looked at each other in a new, different way as if to say: "I never noticed this about you..." Understanding feelings
needs a time and a place where they can be acknowledged, and worked through. A group meeting functioned sometimes as an experience that allowed feelings to be faced and owned. It was as if a door has been opened and then a more "honest" fuller response to the difficulties had been permitted. Husbands and wives were more open with each other. We often saw the paranoid suspicion that was expressed that could "fester" unspoken between the father and the mother of the premature baby. Amazing accusations were made in the meetings at times such as: "she got rid of the baby because it was mine, she did not want to look after my baby!" to "we made love, it was me that pushed the baby out!" and so on. I hoped that voicing and discussing these issues in the open might reduce their powerful paranoid weight.

The fact that this is a common process that most parents go through, can be helpful if it is acknowledged, recognised and accepted. If the group works well, parents can then own and become more aware of their difficulties.

It was often the case that some change in peoples' feelings occurred in the group, (looked at in Section 5 of this Chapter), as if some containment was achieved by the group work.

The acknowledgment that the parents had undergone a most disturbing experience, that pushed them off-balance, and from which they would need time to recover from, had to be repeatedly stated.

Another phenomenon was often "laid bare" in a parents' group meeting. It seems that trauma plays havoc with the sense of time: babies were talked about as almost grown up one minute, able and lively in their response to the
stimulation of life on the Unit. The next minute hidden anxieties were exposed and the same baby was spoken about with the almost factual conviction that it would not grow up, that it would always stay in the Unit attached to the ventilator.

Joan, a mother once said two sentences about her baby who had just had corrective heart surgery. The first sentence concerned how worried she was about her baby surviving the operation, the next sentence was how she was going to feel when she went swimming in her bikini! In one moment she moved from being mother of a very ill infant, to a teenager who is well and goes swimming and is worried about her scar. (I wondered if the mother felt terribly scarred in talking about her baby. It seemed too risky to continue in that line of thought and the risk became consciously to do with Joan's scar.) I was able to highlight this swing of focus, from the terrible feelings about Joan's operation that was a present worry to Joan the healthy teenager on the beach in a bikini in the far distant future. We could recognise these swings as a phenomenon that was familiar to all. We were able to try and stay with the worries about Joan's operation.

Thinking about the crises the parents went through made me wonder sometimes if some of the mothers unconsciously felt intensely envious of the level of care their baby was getting in comparison to the level of care that was available to them.

Trying to separate the phantasy baby from the real one

Another area which was usually fraught with difficulties was; what sort of baby the parents had and, what could they expect. Parents' feelings swung violently from
intense anxiety about whether the baby would live to mania of "there is nothing wrong with him and he is just normal". The parents had a strong wish to regard their babies as "normal", meaning there was a strong wish to see their babies function in the same way as full-term babies of the same age. It was often not the case. Some pre-term babies had eating and sleeping difficulties (The Lancet August 93, see also Chapter 3 above referring to the special play group in the Hospital Child Psychiatry department).

The parents' group helped parents go through a sort of process of mourning, whereby their "dream baby" was separated from the real baby they had. His future possible difficulties as well as his strengths were acknowledged. There were many examples of parents being able to talk about their worries about the future of their child: would he be normal? would he catch up? They are given some of the facts about the usual premature baby development so that the parents were somewhat ready and would not develop serious anxieties later around feeding.

Summary

This section describes some of the reasons for starting the parents' support group in the Neo-natal Unit. It looks at the emotional needs of parents of premature infants that can be worked with in a parents group.

There were limitations to this work: we did not see all parents, or we do not see them for very long, but it seemed to be a start or a brief intervention opening a door for reflection.
It was a collaborative work between the medical and nursing staff and myself that could not have taken place without the awareness of our mutual dependency.

6.3 The structure of the parents' support group

The Background

I approached the Nursing Officer and discussed the possibility of starting a regular parents' support group meeting. My suggestion was based on the structure of the staff group, (discussed in Chapter 4) namely a staff meeting to which I was invited but which was chaired by a Sister.

I suggested a similar structure for the parents' support group: the meetings could be organised by one of her experienced Sisters, who would invite all the parents, and chair the meetings. The Sister would have the task of trying to make sure that new parents were aware of the group, and in the meetings she would be consulted and offer advice on practical issues, as well as being a link person with the staff of the Unit. I would be there as the psychotherapist of the Unit, dealing with the feelings and anxieties as they came up. The issues that came up in the meetings could then be shared with the team as a whole, if this was appropriate, via the Sister. This structure was in fact adopted.

The Sister invited the parents by telling them about the group, or leaving a note on the bedside when they are admitted if she missed them.
Her involvement and later, that of a Staff Nurse, proved to be crucial. They were the managers of the parents' group and I was left to be the psychotherapist. (The Sister is now doing a counselling training course paid for by the Hospital.)

The shape of the meetings

A pattern gradually developed for the meetings of the parents' support group. Issues had to be resolved as they came up. There was now an agreement as to the time, place and shape of our parents' support group meetings.

The meetings took place on the Unit in the parents' sitting room. We had a formal part that lasted an hour when one parent at a time talked and was listened to by everyone else, rather than a free-for-all chat. We met in the evening at 8 pm which enables fathers to join, and it was after feeding time on the Unit.

After a brief introduction about the purpose of the meeting by the Sister and myself, we listened to the parents. They usually talked about their experience of the birth, the health of their baby, and other members of the family's response to what had occurred.

Some parents brought their babies into the meetings either from the Unit or if they had been discharged, from home. Babies were fed in the meetings but were taken out to be changed.

After an hour when the formal part of the meeting was over, the staff left and the parents were encouraged to stay in the room if they wished and talk among themselves. We noticed that some friendships developed between parents.
who sometimes swopped addresses and stayed in touch outside the Unit.

The staff and myself would then spend half an hour looking at the material from the meeting. It was a form of supervision as well as a chance to develop some ideas as to how the work with a parent could continue on the Unit. It was often the case that new facts were discovered about the family in the parents' group. The facts, like a previous loss or losses, (one woman told us about nine miscarriages), problems at work, lack of relatives who could help, etc could be important in the clinical thinking about a case. I shared my thoughts and concerns about a mother who might have struck me as very depressed or very disturbed. We would then think about who we should share our concerns with, her named nurse might be approached or the community Neo-natal Nurse or the G.P.

The psychological issues of the parents' group

The concept of "boundary" derived from Lewin's work (1935, 1936) was very much in my mind when I thought about the parents support group.

Some issues that came up in the parents' support group meeting would be fed back to the Nursing Officer or another unit, Casualty or Obstetrics, either by the parents or the Sister. The boundary was therefore not the meeting of the group.

We informed the parents that issues might have to be shared with the other members of the team. The boundary was the Unit rather than the parents' group. This was acceptable on the whole to the parents. It seemed to me
that powerful transference feelings took place not only between the parents and staff: in particular the relationship to the Consultant was coloured by infantile feelings. He was seen as a powerful, almost superhuman figure, full of knowledge, sex appeal and so on. There was also a strong transference relationship to the "Unit". Like the Consultant or the Sister the "Unit" was idealised. It was referred to as a place and a time where care and knowledge and love were forever present.

The total dependency of the parents and their babies ushered in infantile modes of relationship. Idealisation splitting and denial of anger, suspicion and fear were very common.

The way I addressed transference issues in the parents' support group is looked at in the next section of this chapter.

We used first names as that seemed to be a comfortable way for people to address each other and members of staff. We had, once every six weeks, a meeting where families who had been discharged and were invited to come back to the Unit. It was not clear or rigidly defined how long people could carry on coming back for. My impression was that this varied a lot. Some might want to come for a year or two, some might drop out earlier. A lot of mothers came into the Unit when they had a follow up appointment, to see the staff and be in the Unit again.

My relationship with the Sister

The mutual dependency that was at the core of this parents' support group work was often discussed by the Nursing staff and myself. I do not think that this support
group could have existed if there had been either no Nursing input, or just nursing input without my input. This project has now existed for more than three years. The commitment of the Nursing staff is vital. There was a sense of some recognition of the unique input of all of us. It felt that a time and a space had been established in the "psyche" of the team for this work.

The parents on the Unit

The usual conscious expectation of most pregnant couples is a healthy live baby at the end of a full-term pregnancy. Parents often said that in ante-natal classes they were not interested in the Special Care Unit, indeed most of them had never entered such a Unit or did not know it existed until their baby was admitted to one. This adjustment was very painful and difficult. People often faced the trauma of sudden birth, bleeding etc. They found it most difficult to accept the new reality, which was worse than the one they had been hoping for. They sought urgent reassurance. Staff found this part of their job very tricky and difficult.

Dealing with the parents, I was told, is the most difficult aspect of being a Neo-natologist, (private communication from a very experienced paediatrician). When and how to address very worried parents was an issue that comes up again and again in staff meetings. There was a sort of private language in the Unit that Doctors and Nurses used and parents learned slowly to understand. It seemed to be an attempt not to alarm, it was a form of understatement that could be misunderstood at times.

A good example came from an account of a grandmother who complained that she totally misunderstood the severity of
her grandchild's condition. The Consultant was telling her that the baby was "very poorly". The baby died soon after that conversation. The grandmother missed the meaning of the phrase "very poorly". She told us that she used the phrases "poorly" or "very poorly" when she has the flu or a cold.

The parents' resistance to facing some of their anxieties, has been looked at in connection to their powerful unconscious anxieties, (see Chapter 5) as well as the more ordinary wish to keep their feelings private to be dealt within their own families.

**Difficulty in staying in touch**

One result of this project was to make me realise how very disturbing a premature birth is, not only for both parents but also for the siblings and the grandparents! and how easy it was for myself and the staff to underestimate the level of disturbance in the family. I think that it is possible to become blase, or turn a blind eye (Steiner 1985) and join in the wish to reassure (Feldman 1993) that all is, or will be well.

The risk in this project was of becoming thick-skinned so that only the most dramatically frightening cases would impinge on me. I needed a reminder every so often. It was very helpful in the staff meetings to ask a newcomer to the Unit to help in giving a fresh impression of life there. It seemed that as I got familiar and felt at home in the Unit I ran the risk of not realising how a newcomer might feel, be it a new nurse, a parent or a new baby. It seemed to me that a similar process took place in the staff of the Unit. It was the price of becoming "experienced" that one could become distant from the
ordeal of the parents and the babies. I felt that I needed constant reminding of this. Menzies Lyth (1986) and Bain (1982), following Bion suggest that the worker should "cultivate ignorance" in the situation, try and look at the problem from a new and different angle. Infant observation of a mother and her infant helped me to see more clearly her difficulties.

The inability to face reality, to turn a blind eye and reassure is in all of us: staff as well as parents. The level of anxiety in the Unit was so high that powerful defences were mobilised by everybody: parents and staff and extended families were all trying to reassure each other. A group that attempted to face these anxieties was necessarily a threat to the existing defences and was very difficult to sustain.

Summary

This chapter follows on from previous ones in which I tried to show the work with the staff (first informally on the Unit, then in the staff group meetings), where their feelings, anxieties and defences were somewhat contained. I am suggesting that the defensive nature was somewhat modified to be able to support a closer involvement in similar work with the parents of the babies on the Unit. Change has been on the whole tolerated, and even welcomed and supported by the staff, not only in their attitude but also by their actions. However like an analysis there were also episodes of "negative therapeutic reactions" when what had been offered was rejected.

It seemed that a parents' support group could confront and look at some of the issues that arose as a result of a premature birth. It also seemed that it was very difficult
to establish an on-going regular parents support group. The unconscious resistance to confront painful and frightening phantasies was only one of the difficulties.

How ready the parents and the staff were to face the painful issues surrounding premature birth was not clear. Steiner (1993) argues that the analyst might do well to address the patient from the position the patient is in at that moment: namely start from what the patient feels consciously. I found that working with the structure as it is was the time enables me to start.

In this section I looked at the structure of the parents' group: it was underpinned by the support of the staff who chaired meetings, announced its existence and participated. It was an opportunity for the parents to think and talk about what had taken place in their lives. For the staff it was a chance to listen to the parents without interruptions.

What is the value of this work? There is no sense that it is an on-going therapy group, as the same people do not attend. The continuity is located in the staff. We are always at the meetings, as are one or two parents who have babies that are at the Unit for weeks or months, and other parents come once or twice.

It is used by the staff to learn about parents. The doctors often say now "did any of this come up in the parents' group?" It is acknowledged as part of the service the Unit offers. Parents' feelings and their presence is more prominent in the thinking on the Unit.

As for the parents, I feel we are offering some emotional first aid. We acknowledge that they have been through an
They can, after talking about it, think and talk to their partners, metabolise what took place, try and separate the facts from the anxieties. In the next three sections I want to look at some of the meetings of the parents' group, the issues that came up and the insight that became available as a result of the work done there.

6.4 A parents' support group meeting

Introduction:

In the following I discuss a parents' meeting showing some of the feelings of the mothers towards the Consultant, the Unit and the parents' group, also their feelings about themselves as mothers of ill babies, and their suspicions of how they feel the world is seeing and judging them.

Background

Five women came to this meeting. Molly was an unmarried seventeen year old, who had given birth to twin boys born after 29 weeks gestation. At the time of the meeting one of her boys had died, the other one was very ill. The father was not coming to see her or the baby. Molly's mother had come to the meeting. She, the grandmother was in her fifties and had three daughters, and Molly is her youngest and the most difficult. (Grandmother told me that Molly was a patient at North-Gate which is an in-patient unit for disturbed adolescents.)

Lily was an eighteen year old unmarried mother of twins, a boy and a girl, born also very prematurely at 29 weeks gestation. Both babies were in intensive care, on
ventilators. At the time of the meeting both were very ill. Lily's was her elder sister Kate visited her every day, and came to the meeting.

Ruth had given birth to a Down syndrome boy, eight weeks prior to the meeting. John, Ruth's son, not only had Down syndrome but was ill from birth with a serious blood condition. She had been told that he might not survive and she had talked to her priest about arrangements for the baby's funeral. Ruth was a very religious woman. It seemed that she was very ambivalent about this child, unconsciously perhaps wanted him dead and felt terribly guilty about her feelings. John had survived, his blood illness had been treated successfully, and he was discharged two weeks before the meeting.

All the women had been discharged from maternity wards some weeks before the meeting. Two had babies on the Unit at the time of the meeting. Also present was Eli, the Sister who ran the parents' group with me.

The meeting

We started the meeting and Eli asked how Ruth had been since her discharged two weeks earlier. Ruth responded "It is O.K. but very difficult. John has a cold, my husband done his back in, and Brandon my four year old son is playing up. He gets up at five in the morning. Somehow he managed to get to the garden and he gave all the bread to the birds. He did that by climbing on a chair undoing the bolt on the top of the kitchen door. He and my daughter Caroline play with John. They are rough. This sort of baby is different. I read in a book they are different and I cuddle him. The others are in shorts and he is wrapped up in a blanket. I am fed up and I have come here for a bit
of comfort. My husband does not like to come here so he is looking after them at home.

I said that it seemed to me that there was a possibility that the meeting in the Unit could be seen as bit of comfort, that cuddles people from the outside difficulties, a sort of emotional warm blanket that is needed.

Molly and her mother then said spoke but it was the grandmother who says "when we came into the Unit we did not understand what it was all about. The Doctor talked to us but we could not take it in. He used the word "poorly", the baby was "very poorly". We looked at the nice pictures on the walls here and we thought that Jack was ill but that he too would recover. His illness we thought was just a phase. After all I say the same words "very poorly" when I have flu! And then the baby died".

I said that what I learned from what they had said was that they felt that they had been badly misled. The pictures were looked at rather than the severity of the situation, which was not clear; they were saying that they did not need to be cuddled.

Lily said that when she came in and was told how ill her daughter was she cried, and she was sure her baby would die.

Ruth said that the Doctor had told her that John's condition was hopeless and she therefore should come and give him a last cuddle, but she said that she had not been able to listen to that, and had left the room. The Doctor talked about turning the ventilator off. Her husband was very cross because there would have been no baby John.
When she took him out and a man in the street had said what a lovely baby he was, Ruth was not sure if he was speaking out of pity. She noticed that people were behaving differently: they came to visit but had come for her other children, so why were they coming now?

Her comment could be referred to us too, I said. She had been invited to a meeting here with us because of John, but there had been no meeting like that when the others were born. She might feel that I was like the man in the street feeling sorry for her. Lily said she had not noticed he was a Down baby she thought he was lovely, and Molly agreed. I said that Ruth suspected that we pitied her, like the man in the street.

We then moved to the discussion to see what people felt about their partners. Ruth said that her husband had not shown any interest in John. He had done his back in and wanted sympathy from her. When she was ill she just wanted to be left alone, and if her husband came in with tea she did not want to know. Molly said that Ben (her partner) did not come to see Dan (their baby). He had gone to Jack's funeral, but was not interested now. She said that she would not have him around later on: it was her family that came to the Hospital every day, whereas his mother only came on her way to go shopping.

Lily's sister Kate talked about her boyfriend who had been very disturbed when she told him about Lily's pregnancy. She said that their brother took over and his wife felt left out, and he would have many babies, if he could get pregnant, her brother wanted almost to be a mother.

It sounded as if the group felt unsupported by their partners who could not help or were not interested, or
wanted to take over. No one was offering the right help. It seemed to me that the Unit too was felt to be either taking over their role as mothers, or was totally indifferent.

Molly said that she had tried to talk to Tina (another mother who had twins on the Unit) but Tina had ignored her. Molly had wanted to find out what was wrong with Sera (one of Tina's twins), who was terribly ill at the time, because she was afraid that Dan would catch it, "after all we are all in the same boat". Eli the Sister said that she thought it was not a personal rejection: Tina was very upset because Ann (her other baby) was very ill.

Molly said that the Doctor had seen her for five minutes. Lily said "same here, just five minutes". Ruth said that she had been terribly upset when she heard that he was going on holiday to America, and thought how irresponsible he was: how could he go on holiday when John her baby was so ill?

I said that there was now a sense that the Doctor like the partners, was not interested. I wondered if they too would like to go to America and leave their concern behind. Molly said that when he, the Consultant, had spoken to them, they had not been able to take it in, they did not want to know. He had told her that John was very ill but she could not take it in.

I thought that the group felt totally unsupported, and angry with partners and Doctors as uncaring or feeble, as well as envious because they could stay away. The group was also suspicious of the meeting and our role in it. It
could be seen that we were interested in pitying them and triumphing over their misfortunes.

That ended the "working" part of the group and Eli and I left the room, the group stayed in the room for another 40 minutes.

Discussion

A frank and open discussion is presented. One of the main themes is that of being unsupported by partners and being ignored and abandoned by the Doctor.

Another theme is how other people see the mothers of damaged babies. Ruth's account of meeting the man in the street implies she feels treated with pity. It is linked to the persecutory feeling of being pitied by the staff, who are mainly women, who in phantasy are mothers of well babies with supportive partners. This is linked to the questioning the purpose of the meeting? What do Eli and I get out of this? Do we come to pity and gloat over them?

There is a sense of envy of the Consultant who can up and go to America, with no sense of the heavy burden which the mothers feel. Having some idea of what is presented I understood this material to be the group experience, although one or two members said all this

Working with the group processes

In this way of working I was influenced by Menzies Lyth, "one works with group processes and the individual as related to them, and not with the individual separately. Every member is always engaged in the group dynamic, even if he is absent, this is linked with the point made above:
that models imported from psycho-analysis directly are not relevant since they are based on a two person relationship, with group membership held only in the minds of patients and analyst" (Small Group Theory). The women in the meeting all had babies or were related to babies on the Unit. Almost all of them were damaged: A Down baby and two very premature sets of twins (at the time of this meeting one of Molly's boys had died). Mother's persecution, suspicion and sense of being let down by their own bodies, their partners, and the Unit is expressed. We listened and acknowledged their experience. The mood in the meeting was very serious. I felt very tense and unsure as to what right thing to say was and what might be too theoretical and therefore remote.

Why this process should be of any help to these mothers with their disastrous gynaecological history was often in my mind. Bion wrote that the mind needs truth to live as lungs needs oxygen, and Segal wrote about the therapeutic value of insight. In her paper "What is Therapeutic and Counter-Therapeutic in Psychoanalysis" she writes "it is insight that enables the analysand to regain parts of himself lost by projections, to integrate what has been fragmented or split, and this in turn alters his perceptions and object relationships. Insight is also of importance for lessening omnipotence and allowing a non pathological introjection of the functions of the analyst"(1983).

At this point I can only say that my experience was that Bion and Segal are right. The burden of these mothers' fate was made worse when their pain went almost unacknowledged. The meetings were an attempt to listen
seriously and think about the experiences and what they had caused.

Transference

This is an essential subject of psychoanalysis. It was viewed by Freud as a displacement of feelings and as an obstacle to progress. In "A Case of Hysteria" he writes "What are transferences? They are new editions or facsimiles of the impulses and phantasies which are aroused and made conscious during the progress of the analysis; but they have this peculiarity, which is characteristic for their species, that they replace some earlier person by the person of the physician. To put it another way: a whole series of psychological experiences are revived, not as belonging to the past, but as applying to the person of the physician at the present moment" (S.E.7).

Freud goes on to say that transference is not created by psychoanalysis it merely brings it to light.

The group feelings of suspicion and persecution are not only a result of infantile transference. The members were completely dependent on the skills of the staff, the Doctors and the Nurses. There were reasons to believe that at least two mothers were psychologically very immature and disturbed young women who had come into this Unit loaded with very severe emotional difficulties before their pregnancies. It did not seem right to me to make simple transference interpretations in the group. It was not a therapy group, I therefore spoke as I described above, in a way that I thought might be meaningful to the members of the group, whilst mindful of the obvious transference references to the feelings towards the
Doctors, the staff and myself. There was a worry, voiced in the meeting, although I did not think that the mothers were conscious of it, that purpose of the meeting was to pity the mothers, like the man who had talked to Ruth in the street about her Down baby. It was possible to think of this as a projection of an unconscious sense of the mothers being pitied by their internal parental figures. There was a sense that figures who should have offered help had neglected and abandoned the mothers: partners, doctors and perhaps the team as a whole were felt to have neglected these women by discharging them and sending them home.

The babies of these women were all very small and ill. One baby had died. I thought that the fear of these babies dying was not far from everybody's mind. The fear that they were left alone to try and keep these babies alive, as no one cared very much about them or their babies.

Summary

A parents' group meeting was presented in detail. The group was struggling with paranoid suspicions i.e., that the purpose of the meeting was to pity or triumph over the mothers. The group felt very unsupported by their bodies, partners and doctors, at the same time as fearing of being taken over and controlled. The unit, too, is felt to be too protective or taking over. The group consisted of mothers of terribly premature and very ill babies. It often struck me that some of the mothers of babies on the unit had come to this terribly difficult situation already overloaded with a heavy burden of previous difficulties. In this group of five mothers there were two unmarried young teenagers who seemed to be very immature psychologically, who had "acted out" their emotional
problems by becoming pregnant. They very rarely, if ever, talked about being worried about bringing up premature or ill babies. They usually came across as denying any worries. The meeting was an attempt to face some of the feelings that were unconsciously around, to try to think about them and thus bring some understanding and perhaps some relief.

6.5 Second clinical example. 
A "Psychological ultrasound"

Introduction

The parents of babies on the Unit go through a painful process of mourning, with its fluctuations of manic denial, triumph, depression and splitting seen in the meeting presented below. The following account exposes the process and shows some of the emotional movements, my intervention and the response to it.

The parents' support group meeting

There were Three mothers, a baby, and a father, together with Eli the Neo-natal Sister and myself. Eli started by asking us to introduce ourselves. I said who I was and what my role was. Jason's mother said that he had been born twelve weeks prematurely and he was now three months old and was going to a big cot any day now. (Jason was not only very premature but very seriously ill, with severe brain bleeds, causing concern that he would be physically damaged for life with paralysis. He had also undergone major surgery to his abdomen. At the time of the meeting he was on oxygen). Jason's mother added that he would have to stay a while longer on the Unit, as she
lived on the third floor and her mother (who is in a wheelchair) would be looking after him when she went back to work and she, Jason's grandmother, would not be able to deal with the oxygen.

(She was referring to the offer the Unit makes to some families to take babies on oxygen home, rather than stay on the Unit. Babies sometimes need to be on some supply of oxygen for weeks or months. In this case the offer to take Jason home on oxygen was turned down).

This mother added that she could not wait to go back to work. The same feelings had been expressed, she said us, by Camilla whose baby Darren was very premature and had nearly died, and Kate, another mother of a very ill and premature baby. I talked about the need to feel reassured by going to the familiar adult world of work, away from the new and worrying world of prematurity, illness and oxygen. Nothing at work could be as difficult. I thought that Jason's mother was also telling us that the burden of Jason's condition was too much for her wheelchair-bound mother. It was clear that she was saying that her internal and external resources were insufficient to cope with such a burden.

Suzanne told us about her son, Ken who was a full-term baby, who had become very ill and nearly died the day after he was born, and was rushed into the Unit. She had almost gone home the night before with Ken, when he was just a few hours old, but the nurse convinced her to stay another day as she, the nurse, had not yet done her notes and luckily his condition (terribly low blood pressure) was then picked up and he was saved. Had she gone home he
would have been dead. Investigations were being made but they had found nothing.

Peter, Ken's father, said that he could not get over the size of him; "Ken is such a big baby!" I said that we tend to see size as evidence that all is well. He was reassured by Ken's size and was shocked by the sudden enormity of the illness. He was big but not well. Susanne agreed.

I said that we were looking at the terrible sense of babies nearly dying at birth or not surviving their infancy, the horror of this experience, the fear, and wanting to run away from it all, being "misled" by what seemed to be evidence of health like Ken's size.

Julie, as if encouraged by all this, then told us that she had her baby, Hanna, after only 25 weeks of pregnancy. so Hanna was fifteen weeks premature. Julie, a good looking young woman, then told us than that she had lost a baby at sixteen weeks last year. She had been told that the baby was dead, and had died four weeks earlier at twelve weeks of the pregnancy.

Suzanne then told us about a similar experience, she had had an ultrasound in her previous pregnancy, and could tell that all was not well. She was told the baby was very small, and the picture was put on a bigger screen and a second doctor came in. This doctor then said "it is dead" and left the room. Nobody wanted to know or talk about it. Suzanne then asked Julie what had happened to her, and Julie said that she had miscarried. Susanne said that she had had to be induced, but later there was
concern that her inside was bad, and that she would not be able to carry a healthy baby to full-term.

The Parents Group as a form of an emotional ultrasound

The group was looking at the awful facts that some babies died and could not be saved (Julie's and Suzanne's first babies). Would the new ones be different? If so how different? Would they really be well, or half dead and damaged.

I thought that we were having an emotional ultrasound session, looking at some very disturbing pictures. What was it inside people that made their babies well, grow healthily or that made them perish.

Jason's mother told us about the doctor who had said to her "you are lucky you are with this consultant,, another one would have let you miscarry, he gave you the drug and that is why you have Jason". She also said that she had to have another "thing" done, as part of the placenta was still inside and she was in constant pain.

It was all a matter of "luck"; she was with this particular doctor and she had had Jason, who was a premature, very ill baby. Was it really lucky? or a terrible misfortune. I did not say anything to the group about the nature of luck or the lack of it. It seemed that people were struggling to feel "lucky", as a flight against a sense of depression and failure, as mothers and human beings, who, when closely examined are found to have dead babies inside like Suzanne and Julie. Jason's mother was feeling luckier that the other mothers.
Jason's mother then said that when the doctor talked about the brain damage that Jason had suffered she had been shocked. She had thought about it as a bleed in the brain, as it had been described originally, rather than brain damage.

I thought about the use of bland language to protect the Doctor and the mother from the painful truth, and how much this "protective language" was used in the Unit, how quickly people learned to use it and how, and from whom they learned. It had become the Unit's language: it separated the people inside from the people outside. In the meeting too we talked about being "lucky" and "unlucky" as a form of coded language for feelings and facts that are too painful to talk about plainly.

Jason's mother said "Maybe it is because they are men they talk like that. Why are so many men gynaecologists? You lose all your dignity when you are pregnant, I hope I never see them in the shops I will be so embarrassed".

Suzanne said that one doctor had brought in all his students and was talking about her and her baby as if she was not there. He had not even asked for her permission. She then told us that Ken's middle name was Milton, after the consultant who had looked after him and she felt, had saved his life. She had written to tell him and he had written back and thanked her. "Was not it nice of him?"

Splitting in the meeting

At this point there was some sense of splitting between good and bad Doctors, and mothers and sexual women who
might feel excited or embarrassed and curious about the men who were Doctors.

There were good caring doctors and uncaring ones, good caring husbands and uncaring ones.

I said that the mood was shifting from looking at the facts as mothers to looking also as women, at doctors who were also men. There were some smiles. I added that no doubt sometimes this meeting too was felt to be of use and sometimes like an experience of the doctor and his students, we were seen as just listening to them to learn but not to help.

Jason's mother talked about her husband. She said "When I came here last time I was talking about him and then I went home and felt as if I betrayed him and I could not go to sleep and I cried. I cried and cried and he said to me what is the matter and I told him and he said it is O.K. He has a mate at work who looks after him and he talks to him. I wish he could come to the Unit but he cannot come, and now we are so close and we can talk about anything and I love him to bits." Susanne said that when Ken was brought to the Unit it was her husband, Jim, who went into the Unit; she could not come to look at him and he helped her very much.

Julie's husband said that he was very worried about her: last year she lost the child and he was worried about this one. He thought that once it was born she would be OK but he said she cried all the time and she wanted to be in the Unit but he could not stand being here. He said that he had bought her a mobile phone because otherwise she is just at home so she could phone the Unit. Julie said that she phones in the morning and in the evening and she
was afraid that they were fed up with her and Eli said "we are never fed up with mums."

I said that what she was saying was very important, and was part of what we needed to hear, the worries that she was carrying. The meeting was a form of mental ultrasound, not as sophisticated, but we did get to see some of the feelings of parents, their anxieties or depressions.

I think that hearing about these feelings is important. We heard some thoughts about how would parents manage to look after their babies and keep them alive. Should some have been left to die? I learned from listening to everybody that they were carrying strong, sad, worrying feelings that in turn made them worry about the thoughts and feelings they had. As though they questioned whether their thoughts were normal for a mother or a father to have?

Julie told us she that was upset and worried stiff. "I want to know what and why it happened, will it happen again?" She wanted to be reassured and be comforted. Her husband said she cried and he worried about her. She then said; "I do not mind if he does not come. I'd sooner he did not come."

She had not been to the end of the Unit where Jason was and Jason's mother invited her to go see him. She said that she had felt just like that three months ago, and someone else talked to her. Julie was crying.

I said that there is also a worry here about the Unit. Would the Unit care for babies if critical resentment and suspicion are expressed. Could Julie and the other mothers express their hate, depression, sense of failure
and being unfortunate and still feel cared for? At this stage the formal meeting came to an end and the parents stayed talking to each other whilst the staff left the room.

Discussion

I felt almost overwhelmed by the accounts of obstetric injuries that had been reported. The meeting started by Jason's mother reporting that she and her mother could not cope with looking after Jason yet. He needs the care the staff were giving and she needed the meetings. She had not got the "mental oxygen" to look after her very ill son.

Klein in her paper "Mourning and its Relations to Manic-Depressive States" (1940) put forward the view that the loss in a state of mourning is not only of a loved external object but also the fear that the inner parental figures are damaged and hence unable or also unwilling to help and support the new mother. This unconscious burden was sometimes projected onto the staff of the Unit and we heard another mother's worries about whether her baby would be looked after in the Unit and whether her concerns and difficulties will be supported.

These and other worries were voiced, and the group then had the experience that their worries had been listened to. The same theme then returned again and again. One mother was crying unconsolably. A husband tried to be helpful to his wife, Julie, by buying her a mobile phone so that she would be able to "get in touch" with the good helpful Unit. The helpful object/team was demolished when Julie believed that her inside, that did not support her previous pregnancy was projected, and the Unit became
a dangerous place that could not look after her baby. She felt she had to be at the Unit all the time, not only to be with her baby but also because she could not trust the team.

Partners and doctors were viewed in two ways. I noted the change and splitting from the bad men to the good men, who became both helpful and sexually interesting, or exciting. The feeling that Jason's mother was closer to her husband, despite the awareness that they had a very ill baby, seemed to come after she had talked about him and her worries about Jason at the last meeting.

Some differentiating was achieved, and with it a sense of some relief and vitality. We had dared look at the internal "ultrasound". We looked and saw very disturbing feelings and thoughts. We had managed, with my help, to reflect somewhat and there was a sense of some movement in the meeting, a bit more vitality and trust in the existence of good helpful figures, as if some separateness was achieved. It was the babies that were very ill. The parents were somewhat less confused with them. The Unit in turn was not so mixed up with attacking internal objects.
6.6 Third clinical example. "Wanting another baby"

Introduction

This meeting was with parents whose babies had been inpatients for a long time on the Unit. All four babies were on average more than ten weeks premature: one had been transferred to the Unit a few hours after birth with serious heart defects needing surgery, one had needed abdominal and throat surgery, two had been on oxygen for many weeks. One of them went home "on oxygen".

The parents kept in contact and came to the Parents Group after the babies were discharged. Some had journeyed a long time, more than an hour from another town, to come to meetings.

It seemed that they had become attached to each other and to the group. I bring this example of a meeting with "ex Neonatal" parents to try and think about the nature of the more long-term worries that they discussed a few months after discharge. The babies were about seven to eight months old at the time of the meeting.

The meeting

The group consisted of four mothers, three babies and one father. Before the meeting started formally we were sitting in the parents' sitting room on the Unit, and mothers were asking about each others' babies: what did
they eat, did they sleep all through the night, and how much did he or she weigh.

The meeting then started with Dina telling us that her son could now sit up. It produced a very pleasurable response from the other parents. Kate then told the group that her daughter was now without the oxygen tube. It had been taken off 4 weeks before. She said "It was really wonderful." She told this with great sense of achievement, and we all looked at Linda on her mother's lap with no tube coming out of her nostril attached to an oxygen bottle.

Kate was treating her baby as if she was very big. She handled her with confidence, even more, with love? The previous time I had seen Kate and Linda at home, Kate had appeared to be detached and cold (described in Chapter 7).

Elinor told the meeting that her son now weighed about fifteen pounds and was quite heavy. She reminded us that he had been born very prematurely and had weighed only about one pound! Tina asked if he ate solids and said that her daughter did not want to eat any solids yet.

Linda began to cry. Kate tried to give her a bottle and to change her nappy in the room. Kate did not want to leave the room. She handed Linda to a doctor who took her out to feed her or pacify her. Kate seemed to want to stay with the group of parents to be like the other parents whose children were growing and thriving. It seemed to me that she needed to have her status as the mother of a baby who did not need an extra oxygen bottle and who could breath and was alive and enjoyed.
Dina told us that she felt a lot less worried now. She said "It was so good when we left the hospital and came home. It was such a long time. We used to live on the Unit! Spent all our time here. Just being here." Their son had been on oxygen for many weeks. She could not face taking him home with oxygen, it was too terrifying.

Tina said that her daughter, Joan, needed one more heart operation. She said that she had done very well after the other one. The doctors had been very encouraging and said she would not need as many operations as they had thought originally. Joan had a double problem with her heart: she had a hole in the heart and it was that hole that kept her alive, which was a paradox. Tina described more medical details, and then said "I feel that Joan is my daughter now, not like at the beginning."

Dina again said that she was not worried about her son now. Terry her husband said that that was not quite true. They still had him in their bedroom; he still felt like checking if he was breathing; they still had the alarm under his mattress. Tina asked how long Terry thought they would keep the alarm under his mattress and Terry said "til he is 20 years old". Everyone laughed.

I said that they all felt much better, more confident about themselves and their babies' future. They were all doing well. Growing, eating breathing, They looked back on their painful time in the past with relief. They were growing into being parents, like their babies were growing up. Tina felt Joan was her baby. Kate knew that Linda was her baby and so it was with Elinor and Dina and Terry.
I also said that we were very aware that one of the problems for parents who had babies on the Unit was that they sometimes felt as if their baby belonged not to them, but to the "Unit" which was keeping them alive.

Tina asked if anyone was going to have another baby. She said "I am so furious with the doctors. I felt when I had Joan that I was left behind. My husband just came in for a minute to tell me that she was being transferred. He went with her. I was left behind for three days and when I came I felt everyone else knew my baby and it was as if I was in the way. Now I worry about having another normal baby and how it will influence my relationship with Joan? I could love the new baby more if she wasn't a cause of such worries, and Joan will feel left out, rejected and jealous."

Terry said "if we have another baby I will make sure that Dina will just do nothing will just sit on a chair and I will do everything. Wherever we will be living I will make sure that there is a very good neo-natal Unit in the hospital."

Elinor then talked about the operation Thomas had had for a hernia repair at Great Ormond Street and the fact that Simon, the consultant had to insist that the trachea also needed attention and Thomas had had it repaired. She added "He will not eat any solids: do the other children eat solids? He is very difficult to feed".

Dina talked about her difficulties of feeding her son, and also said that he would never go to bed. She said that he fell asleep on her lap, or in their bed. Terry added that he would eat from his father's plate. The
conversation then became a general discussion about the right type of food.

I said that there would seem to be worries about giving the babies the right food, and the right environment to keep them well and thriving. It was as if people were asking if they were good parents. "do we do the right thing? We are not sure, look at what happened to us, we had premature ill babies." I wondered if the fact they had premature babies made them have doubts about themselves as parents.

We talked about possible difficulties of feeding the babies: they might be a bit slower, they might not enjoy the food so much. Kate said that she was still on medication, and that her kidneys had to be checked again and that she might have an early baby again next time. But she said it would not come as a surprise, and they would be ready.

Tina was very interested in the idea of another baby. Dina asked "Do other babies have spots on their faces? what sort of veg and fruit do other people give their babies?" Dina also asked about other mothers in the Unit and how many mothers there were on the Unit.

I said Tina was talking about her anger with the consultant and resentment at being left behind. Dina had asked about other mothers on the Unit. I wondered how it felt to come to a meeting in the Unit that had been like a home for so many weeks. On the one hand there was the pleasure that they were away from the Unit, whilst on the other hand they had become a bit attached. They wondered if we on the Unit still had a space for them, or if we
were so involved with new mothers and babies that they were forgotten.

Every one smiled. I thought that they worried what we thought of them as parents. Did we think they were good parents who cared and gave their babies good veg and good care? Terry said that they felt that they had been treated differently to the others in the Maternity Unit. Tina said that it might influence her decision of whether or not to have another baby.

I said that one of the issues that was coming up was how people get to feel that they are good parents, and go for another baby if they wish for one. It was as if they felt they needed someone's permission or blessing, and had appointed us to this position. I thought that they were devoted parents who had been through a very difficult time.

Discussion

Being admitted to the "parents group":

A number of issues were looked at in this meeting of parents of "ex Neo-natal patients". There was a clear sense of relief at the babies of the group all growing well: Linda was breathing with no help from the oxygen bottle, Dina's son was sitting up, Joan's heart was getting repaired, Thomas was putting on weight.

It meant that the parents as well as their children were doing well, and that they now knew that they were able to have babies and to bring them up well. They felt as if
they had been admitted into the "parents group", in other words they felt that they were allowed to be parents.

There were a lot of worries about feeding the babies the right food, the right fruit and veg, and solids, which I thought was another way of voicing the worries about being real parents to real babies.

The staff in the meeting were invited to be the judges on these issues.

The issue of another baby

Hard on the heels of this sense of relief was the worry about having other children. Tina worried about her feelings for Joan if she were to have a normal birth and produce a healthy baby: will she feel like rejecting Joan leaving her behind as she felt the consultant had left her behind when she gave birth. There was a sense that "some staff" did not treat the parents of premature babies as well as they treated parents of full-term babies.

It seemed to me that one of the functions of this meeting was to look at this issue. It almost seemed, as I said at the meeting, that the parents were seeking permission to be allowed to be parents. They seemed to feel that having a premature and ill baby had the impact of taking away their sense of confidence that they had the right and the blessing of their internal parental figures to become parents.

There was a hint that Tina was worried that she might resent her little daughter for being ill as well as taking this freedom to become a parent away from her. In other words there was a risk that Joan, the now recovering
baby, would stay confused with internal persecutors who were seen as disapproving figures. I thought that Terry was talking of being discriminated against in the Maternity Unit, not only as a fact, but also as a comment about an internally disapproving figure projected on the staff in the Maternity Unit.

It seemed that the relationship to the ill baby could get into the relationship to the other as yet unborn babies, and into the parent relationship with himself as a parent.

Summary

A Parents Group of ex-patients who met a few months after their babies had been discharged from the Unit showed us the worries that concerned them at this point in time.

Whilst they were very happy with the development of their babies they showed concern about having a wish for other children. All four mothers were first-time mothers. The meeting was used to look at some of the feelings that stemmed from having a premature baby, wanting another baby and having to deal with the complex feelings this wish highlighted. The way the parents used the group to navigate around this issue was looked at. It seemed that the "parents group" was, among other things an "object" that was to approve and give some comfort and permission to go on to have a wish for another baby, thus helping parents become members of the "parents group" of life.

It seemed that the Parents Group and behind it the "Unit" or the team, representing parental internal figures were felt to support the parents' struggle for adulthood.
It seems that the parents were less persecuted and gained some confidence in their reparative strengths.

6.7 Discussion of the Chapter 6

Some technical issues that were linked to running a Parents Group were looked at in the first part of this chapter. Briefly, I thought that the work with the Parents Group could only be attempted after securing the co-operation of the team.

I felt that certain ground work with the team was necessary in order to facilitate the third stage of this project. The co-operation I got, and still get, from the team implies some change in the unconscious defence system of the team, some sense of being helped themselves and thus interested and able to help the parents.

There was also a new perception of the task of the Unit: not only to help save the babies but to help save the parentalety of the parents.

There were always risks that this project that had been going on for some two and half years might come to an end. I feel that it should be a part of the service that the Unit provides for the parents. It is a chance for some truth and insight to become more available and is as important as the oxygen the babies need (Bion 1951).

Some of the technical challenges in this work

I think that the type of pressure the team and parents are under, necessitates a built-in therapeutic input.
A Neo-natal Unit is exposed to on-going levels of stress that threaten to engulf the "ego function" of the team.

I would argue that they need the therapeutic input as a basic built in factor. They always need doctors and nurses and cleaners etc. A therapeutic input has the same importance, and is needed just as much.

The work in the Parents Group links in my mind to the difficulties I find in working as a child psycho-analyst. It is often a problem for me to talk meaningfully to a child in a way that might make sense and will produce some response, preferably a reflective response. The parents in the group meeting are defended, detached or depressed. The right way to address this group of people is an issue that I find both very interesting and a great challenge.

In working with a child, I find that I aim to give the child not only an interpretation but the experience of being with a thinking object; thinking about him, revealing and sharing this process with him in the session.

I find that I start talking to my child patient before I have a complete interpretation. I share with the child an observation I have made about him and the thoughts that come to my mind about that observation. I attempt to expose him to a non-omnipotent object that does not know, makes comments, mistakes etc. The child I have in mind lives in a very omnipotent world where he believes the grown ups make the rules, know always all the answers, and are never fallible.
It seems to me that the work with the Parents Group is in a way similar. I find that I make comments before I know where they will lead.

In a Parents Group people are not in a therapy group, everyday transference data is there to see but it needs to be dealt with somewhat differently than in an on-going therapy group.

The clinical meetings presented in this chapter in Sections 4, 5, and 6 are fairly typical of the meetings I have. Major traumas are reported. On the whole we get to hear about difficult cases, the ones where babies are very premature and ill. There is usually a very short time to deal with the issues, people might come only to one meeting. The pressure to contain and understand the transference angle very pressing. The data can be and often is very confusing and shifting very quickly. I find the work done with the parents in the support group to be of help to the team as a whole. The comments from staff usually indicate some hope that this or that parent might be able to come and use the support group to get some help for their emotional difficulties, thus helping the staff in their contact with the parents. The help is limited. We see only some of the parents, and sometimes not for very long. But establishing this as part of the service the Unit has to offer has changed the perception of the Unit of itself. It also established that "premature parents" need some emotional help in the mind of the team and the parents.
Chapter 7: Some thoughts on the "Inner world" of the premature infant

7.1 Early object relation in 3 psychoanalytic publications

Introduction

The early life experience of a pre-term baby is very different from that of a full-term baby. The prematurity affects not only the baby but also parents, who feel prematurely propelled into parenthood. It could be said that the "inner world" of a premature baby is unknowable. I shall attempt to think about it with the help of some psycho-analytic papers on object relation, some clinical observations of mothers and infants on the unit, and a brief account of therapy with a nine year old boy who was a psychotic borderline child when referred for therapy. He had been a premature baby and I wondered if his prematurity had contributed to his mental illness.

Early experience of the baby

The inner world of a pre-term baby is not discussed in analytic literature although preterm babies were looked after in an organised way in special wards from the thirties. I think that psycho-analytical publications that refer to "the baby" seem to refer to a full-term baby. The postnatal life, or "birth" or "birth trauma" is, too, assumed to be taking place after full-term pregnancy.

Klein writes about object relation starting from birth, (Our Adult World and its Roots in Infancy, 1959). The
picture from her writing is that a baby is born after a full-term pregnancy and at birth an object/or part object is available. "Like other young animals the young infant has an innate unconscious awareness of the existence of the mother. The infant not only expects food from her but also desires love and understanding. Love and understanding are expressed through the mother's handling of her baby" (Our Adult World p 248).

Klein believes that the ego, following Freud "the organised part of the self, is constantly influenced by instinctual impulses but keeping them under control by repression furthermore it directs all activities and establishes and maintains the relation to the external world" (ibid p 249). The ego according to Klein exists and operates from birth onwards and has an added task of defending itself against anxiety stirred up by the struggle within and by influence from without.

One of the main roles of the ego is the introjection and projection that starts from birth and is the base for the structuring of the infant's inner world.

These activities of the early ego are linked to the early relation to the first object. The mother via the infant projections of all his emotions is felt to be powerfully good or dangerously bad. These projections and interjections are part of the infant's phantasies which operate from the beginning of life.

I found that reading this and other papers raised a number of questions. For example what happens to these ideas if birth starts a lot earlier as happens on the Unit, perhaps up to fourteen weeks earlier? How does the infant cope? Could we find an ego functioning that can cope with the
anxieties stirred up by early birth? Is it the birth that brings about the ego, so if birth is early, could we find the process of projection and introjection operating? What happens to the infant who is born prematurely and is therefore deprived of an object like the mother's breast for the process of starting to build his inner world?

The facts are that the premature infant suddenly loses his containing environment the uterus, is placed in an incubator and may be linked to a ventilator and other machines. In other words there is a "birth" but no "breast". What therefore are the necessary objects and processes that an infant needs in order to overcome his early disadvantages.

In their book "The Psychological Birth of the Human Infant", Mahler, Pine and Bergman teach us about the symbiotic phase of development that starts at the end of the first month of life. In this phase "the infant behaves and functions as though he and his mother were an omnipotent system - a dual unit within one common boundary" (p44). It protects the infant from over-stimulation from outside the boundary of this symbiotic Unit. In this phase there is not as yet a differentiated "I" of the infant from the "non I": no "inside" differentiated from "outside". "The essential feature of symbiosis is hallucinatory or delusional somatopsychic omnipotent fusion with the representation of the mother and, in particular, the delusion of a common boundary between two physically separated individuals. This is the mechanism to which the ego regresses in cases of the most severe disturbance of individuation and psychotic disorganisation " (Mahler 1975, p45).
This important phase of symbiosis must be seriously affected by being kept apart, a sometimes unavoidable fate that takes place in the premature infant's life. We could almost say that the separation takes place before symbiosis has a chance to take hold. The infant if he is very premature spends his days and nights away from his mother being looked after by a team of doctors and nurses. Mother may be present but on the other side of the incubator, not able to do much more than talk to or stroke the infant, while the major care is undertaken by the staff.

The premature mother

Winnicott writes about the mother-to-be and the psychological processes that occur in her mind towards the third trimester of the pregnancy. "It is my thesis that in the earliest phase we are dealing with a very special state of the mother, a psychological condition which deserves a name, such as Primary Maternal Preoccupation. It is a special psychiatric condition of the mother, of which I would say the following things: It gradually develops and becomes a state of heightened sensitivity during and especially towards the end of the pregnancy. It lasts for a few weeks after the birth of the child. It is not easily remembered by mothers once they have recovered from it" (Collected Papers 1958, Primary Maternal Preoccupation p302). Winnicott goes on to describe this maternal state as an illness where the mother is in a state of withdrawal or disassociation: a schizoid phase where the mother is identified with her infant. If there was no infant the mother could be seen as suffering from a psychiatric condition like a depression. She withdraws from the world.

-286-
What interested me after reading Winnicott's paper was: how do the mother and infant get together if the last trimester of pregnancy is missed completely? It would imply that the mother misses out on a very important phase of the emotional work done in the pregnancy. If the state of identification with the baby does not have the time to take place, in what frame of mind will the "premature" mother relate to the premature infant? Something that should have taken place according to Winnicott does not. What takes place instead and how it affects the relationship between the premature baby and the premature mother are questions that I think need to be further addressed.

Summary

Three interesting papers on mother-infant early relation are looked at. The ideas are firmly linked to the life of a full-term baby and a full-term mother. The question that interests me is how we link the ideas put forward in these papers to ideas about object relation of the premature baby and his mother. The object a premature baby is confronted with at birth is not a breast. Birth takes place but an alive object to project into, to love and depend on, to hate and to fear is remote. A symbiosis to protect the frail and young baby is not available. A mother who should have gone through an identification with her unborn infant could not do so.
7.2 Some characteristics of premature babies

Introduction

I want to remind the reader briefly who is being looked after on a Neo-natal Unit and for what conditions.

The first treatment centre designed for the newborn premature infant appeared early in this century. It had separate rooms for mature and prematurely born infants with special aids to protect the small but normal newborn. The units focused on providing adequate nutrition, maintaining body temperature and protecting from infection.

In 1930 the focus moved to help infants in breathing as it was noted that most deaths were associated with frequent stopping of breathing, apnea. In the Forties and Fifties improved incubator design and oxygen use were reported. From the Sixties many more premature babies survived who would not have survived before. The prevalence of handicap has remained stable and relatively low at 6-8% of the total live births (The Lancet 1981).

Many conditions in the newborn require Intensive Care. A list of high risk neo-nates includes:-

Those born of diabetic or drug-addicted mothers;

Infants whose mothers suffered severe blood poisoning associated with pregnancy;
Infants born by Caesarean section because of a variety of complications;

Low birth weight infants, born pre-term or at term;

Infants distressed at delivery;

Infants with infection or post delivery distress eg cardiac, respiratory, gastro-intestinal problems;

Infants with congenital defects requiring immediate treatment, such as heart malformation or gastro-intestinal blockage.

At least 60 in every 1000 live born infants will need some form of Neo-natal Intensive Care if we are to minimise death and disability (Ethics and Neo-natal Intensive Care A.R. Jonson, 1976).

Evidence of some of the infant's activities in uterus


De Casper and his co-workers proved the infant liking for the familiar voice of its mother, the preference shown by
the infant for listening to the sound of familiar stories which had been read to them by their mother before birth.

Evidence of the pre-term baby's early memories from life on the Unit

In my informal meetings with the nursing staff they often talked about babies having character, being strong, or angry. One of the Sisters told me about Ian, a three year toddler who would not allow anyone to hold his hands, in her view because "he has had so many needles stuck in them, poor Ian." Many babies have eating difficulties or speech difficulties, (a large number are referred to the Speech Therapist and the Dietician in this hospital) and I often wondered if this was linked to the baby being tube-fed or ventilatated, and that a memory of his mouth being "invaded" is at the root of these problems. These memories affect the way the baby then relates to the world around him. It is not clear to me why is it that not all babies show these patterns of behaviour. It often comes up in our Parents Group and parents are relieved when these phenomena are noted and discussed.

Some evidence from the literature for long term difficulties of pre-term babies

There is some evidence in the literature (The Lancet 1991, 1993; Paediatrics 1988) that difficulties of pre-term babies persist for some years after their birth. These difficulties result in psychological and special educational needs and use a great slice of the resources in this field in the first ten years of their life. One conclusion from the American project written about in Paediatrics states "A conclusion to be drawn is that many children (45.4%) had unusual test score patterns
suggesting specific intellectual problems, even when IQs were at or greater than normal. The major test score discrepancies used to define these conditions were known to be rare in normal populations (less than 5% in most instances). One can conclude that there was an underlining high-risk characteristic in the very low birth weight population" (p 602, Paediatrics vol 82 1988).

The Dutch research work reported in The Lancet (1993) looked at long-term problems such as learning difficulties and the need for special education in the very pre-term children at the age of 9 years and states "At 9 years of age 155 children (19%) were in special education, compared with 6.5% of the 9 year olds in the total Dutch population. Whereas most of the children already in special education at 5 years of age had neuro-developmental or sensory handicaps, the children who entered special education between the age of 5 and 9 years predominantly had moderate cognitive impairments and moderate behavioural and learning difficulties. More than half the study children who entered special education between these ages were judged not disabled at 5 years of age, although most had some neuro-developmental impairment that would have predicted learning problems".

As many as 32% of the pre-term infants in mainstream education were below the level for their age, compared with 10% of the 9 year old children in the general population. The researchers go on to state "Only 40% of all assessed children and 49% of the children without handicap or disability at 5 years of age were in mainstream education at an age-appropriate level without extra help" (The Lancet 1993 p550).
It seems that both studies point to problems found 5 or more years after birth of pre-term babies. The problems were not well defined medically or psychologically and were not detected early. It seems the tests applied were not sufficiently subtle to pick up the early evidence of difficulties.

**Summary**

It is clear that since the early 1960s onwards the survival rate of very low birth weight premature babies has increased considerably, trebling from 1946 (The Lancet A. Stewart et al 1981, pp1038-1040). It seems that this "new population" (babies that survive now, but who would have been dead before the 1960s) and their families have a range of psychological difficulties that needs a lot more research. A lot of the children reach school age and then need special education, their difficulties only coming to light when they reach the age of 5 or even later.

Some studies link their difficulties to their experience of prematurity. A psychoanalytic study of their start of life should look at the interaction between the child and his mother, the identification process of the child and the projection and introjection that takes place. The premature infant's first object and his relation to it is therefore worth studying in some detail. It might contribute to the understanding of the difficulties some of these children have at a school age.
7.3 Premature infant observation

Introduction

I think that weekly infant observation study starting in the Neo-natal Unit and following a baby and mother for the first year could produce some data that might highlight the problems that to surface 5 to 9 years later (as shown in the Dutch work described in The Lancet 1993, discussed in the previous section). If problems could be highlighted earlier and parents and professionals alerted it surely would be a worthwhile project to undertake.

I undertook three brief infant observations of mothers and babies after the babies had been discharged from the Neo-natal Unit. The first visit to each mother and baby was two weeks after discharge, the second four weeks later. In this section I want to think about the baby's experience. Three babies are looked at, Linda, Jack and Jason. Two were born by emergency Caesarean section. Linda was twelve weeks premature and needed two and half weeks of ventilation; Jack and Jason were nine weeks premature and needed to be in an oxygen tent for a week. All were first born babies. Jason and Linda were very ill as well as premature.

First meeting with Kate

My first meeting with Kate took place one Friday afternoon, two weeks after her baby, Linda, had been discharged from the Unit. Kate opened the door, I entered the living room of a suburban semi. In the living room was Linda. She was "sitting" in a baby buggy facing the sofa. Kate said that she was in the middle of a feed. She took her on to her lap and said "Will we get a burp?"
she stroked her back. "No?" after a minute she said "well, maybe later" and put the bottle into Linda's mouth.

Linda took one or two sips and no more. She was dressed in a pink Baby-gro. She had a small tube running into each nostril. Linda still required oxygen that was fed through a tube in her nose. Kate said "She is on very little, but she still needs to be on it. There is a machine in the hall that takes oxygen from the air and another machine, and pipes so she can be upstairs or downstairs. There is a spare balloon in case of a power cut and there is a bottle that can be attached to her pram. There is a machine that measures how much she takes and I have to pay attention to her colour. If she is pale, it means she is not getting enough oxygen. She might need to have another blood transfusion. She is not allowed in the kitchen because of the the risk of fire. She cannot go out to the shops for the risk of colds".

Kate had picked up this information from the Unit and from someone who had come to wire the house with the pipes. The baby had a bit of a cold and the doctor had been to see them the previous day at home.

All this was told to me with a very straight face, factually. Linda was put in her "chair" facing her Mum. I felt very overwhelmed by the level of anxiety that Kate had to carry, but she seemed to be unworried, or cut off from her worries and feelings.

Linda made facial grimaces and bent her head with her tongue out of her mouth and her hands stretched out, eyes closed most of the time.
Was she defaecating? One eye opened then another, she looked as if smiling but the eyes were not focused. I was filled with worries that Linda was not normal, that she was like a frail un-attractive "animal". She fell asleep. Kate said "She wants a lot of attention, she cries if I am out of the room. She wants a lot of attention and we give it to her but at three in the morning we do not pick her up we go in and stroke her head and she falls asleep. It is because while she was on the Unit at night, if the nurses were not busy they picked her up". The complaint was somewhat subtle but the implication was that the nurses played with Linda at night which they should not have done. (I thought that Kate was handling Linda as if she was a big baby much older and fitter than she really was. I also wondered about her feelings about the nurses who had played with her daughter. There was a paranoid feeling implying that the nurse did something called "playing" that was "wrong". It was they who made her behave badly in wanting attention.)

I said she had lived on the Unit for ten weeks so she was used to this and Kate said that she was getting there slowly, "there" meaning getting Linda to behave more appropriately. Linda was now nearly fifteen weeks old but really should have only been three weeks old. Kate held her and said "I am told she looks like a three week old baby. Now she weighs nearly five pounds and ten oz. She is four times her birth weight. When I feed her now or change her nappy there are these enormous fat legs and fat cheeks! Lovely, she was very small when she was born. Did you see the programme on the telly about special babies? I watched it" (a programme about the Unit in Watford on Channel 4) I said I had and the baby that was shown had been very ill.
Kate said "So was Linda, the second week when I was discharged, I was told she'd got pneumonia, and it was touch and go. I was told I could go home but I was not sure if I wanted to. I was in the hospital for 5 weeks before I gave birth. (Kate had been very ill with a very high blood pressure) in the end I did go home. Did you see Jessica? (another baby that was born at 28 weeks gestation whose mother also had high blood pressure and had undergone an emergency Caesarean operation). She went home two days after us but without oxygen. They took it off, then had to put it on again and then it came off." (I was told by Jessica's mother that Kate had not wanted to stay in touch and maybe Kate did not like her. Was Kate envious about Jessica's progress?)

I said that the oxygen would have been a worry for me in an attempt to acknowledge Kate's tough role in caring for her daughter. She said "I was not sure if I could do it when I was offered to take Linda home on oxygen. I said that I would, and as the time came nearer I was more and more scared. They told me that I could take her home for the day to try, and after that I said "yes". They do not know how long it will be, it can be a few days or weeks or months." She added that Linda's lungs were damaged as a result of the ventilation. She was ventilated for two and half weeks, at great pressure, and she got pneumonia and that was why her lungs were not yet ready.

Kate brought the album of pictures and we saw little Linda on the ventilator and she said "Look, you see the marks on her hands and her heels from the pricks of the needle, (a baby's blood is tested every day to see how much oxygen it contains). Julian (Kate's husband and Linda's father) was massaging her hands and feet because the nurses had said that some babies were sensitive and did not like their
hands or heels to be touched later on. Kate then said "When I went to have a shower today I put her in front of the TV otherwise she shouts a lot. She hates it if I take her Babygro off or even if I change her nappy. She does not like to be put flat in her pram and she falls asleep in the "chair" and is then transferred to the pram."

Linda was very active on the mat. She pushed on the toys that made noises and she tried to push herself forward. Linda was "held" in the chair, I think by the enormous emotional warmth that was showered on her by all the members of her family. But Kate did not hold her, she was somewhat distant. Kate said "Julian just talks non-stop about her. We said we would not do that, that it is so boring but he just does not stop. I am a bit glad that he is at work because otherwise he talks non-stop and I feel a bit pushed out. When the midwife came to visit he talked and talked". He was not home on my visit and I thought about his need to "talk and talk" about his daughter and his feelings about being a father of a premature baby. He told us about some of his worries at the Parents Group on the Unit. There was a sense that he felt that fathering a premature baby might reflect on his own position in relation to his younger brother who had had a full-term baby who was now a toddler.

I was told that he would start working from home but Kate said that she was afraid that he would not do any work, but just play with Linda.

They had to go and buy a bed, but they could not take Linda to Brent Cross so her sister was going to baby-sit. They were sleeping on Julian's brother's bed, and they needed another one. It could not wait because they did
not know how long it would be before they could take Linda to the shops.

Kate said that she was going to see her Doctor about her blood pressure in the following February and another doctor would be coming from St Mary's because she was an interesting case. She had been in the local paper and asked if I had seen it. Someone in the shop had said that they had seen the article and she had had to answer their questions. She said that people were very interested.

Her father came in at that point, and brought some chicken soup from her mother. Grandmother we were told, had a sore throat so she could not come to visit. I talked to the Grandfather who said that he thought that it was important that I should know how difficult it was to look and worry and be discreet. He said that it had been very worrying to come to the Unit and see Linda so small with all the machines. Kate had said that she had got used to them and when she got home she almost missed the machines that she had grown to rely on. I thanked her and left.

Discussion

Linda was very afraid when her nappy was changed. She cried and seems to be frantic, according to her mother's account. It seemed that Kate found it difficult to get close and stay next to such a baby who was so ill and might be unconsciously regarded as the cause of Kate's illness. During the observation the baby was on the chair most of the time. The baby had been ventilated in the incubator for two and a half weeks then was given oxygen with a tube and later had a" tube" like experience with mother, meaning that she was fed but was not given the vital benifit of a containing object. She therefore would
need to learn to depend on herself to develop a false self, (Winnicott) or "a second skin" (Esther Bick I.J.P.A. 1968 vol 49 p484).

The experience after birth: What is Linda's first object:

We read in Klein's paper "Our Adult World and its Roots in Infancy" (1959) that ego functioning exists from birth and the processes of projection into an object, the breast, and introjection of this object are the basic processes by which the infant begins to build an inner world populated to start with by part objects that are coloured by the infant's experience and it's perception of it. "Introjection and projection function from the beginning of post-natal life as some of the earliest activities of the ego, which in my view, operates from birth onwards. Considered from this angle, introjection means that the outer world, it's impact, the situations the infant lives through, and the objects he encounters, are not only experienced as external but are taken into the self and become part of his inner life" (ibid p250).

Klein describes in this paper a full-term baby's first post-natal relation to a first object, the mother's breast. There is no doubt that this is the case in all her papers. "The baby" is a full-term healthy baby.

What interested me was how this part of psycho-analytic theory links with Linda's post-natal life.

Her post-natal life started 12 weeks before the normal full-term baby that Klein and other psycho-analytic writers refer to. Does Klein suggest therefore that the ego functioning of projection and introjection starts at birth, whenever birth occurs? If it is the birth that
stimulates this development of ego functioning we will look to find some evidence of this in Linda. If we find that there is "ego functioning" in a baby at such early age could we also say that the ego functioning, namely projection and introjection exists in a foetus at a similar age. Had Linda not been born could we speculate that some similar processes of projection and introjection, would have already started in uterus?

If that is so, we would be forced to think of the first object as not being the breast but the uterus into which the baby projects its distress and gets its good experience from. The work of A Pointelli (From Foetus to Child, The New Library of Psychoanalysis) describes vividly the intra-uterine environment and the way it changes during pregnancy. She does not state that it is the first object, but sees continuity of patterns of behaviour in uterus and subsequently. I wonder if it could be said that some emotional processes like projection or introjection start in uterus.

If that is the case, Linda lost her first object suddenly. We would therefore expect to see a fragmented internal ego structure that might be a factor in children like Linda who appear, in the studies, to fail academically (The Lancet 1993, Paediatrics 1988). It means that the early depravation that children like Linda undergo makes them prone to the more schizoid borderline illnesses. It would be very interesting to see if in the population of children who seek Child Guidance help, there is a history of Neo-natal trauma.
Winnicott in "Therapeutic Consultations in Child Psychiatry (Collected papers)" describes a 13 year old boy drawing. He writes "It would seem to me that here he was expressing something very primitive and perhaps something which belongs to the very beginning before environmental adverse factors or deficiencies began to affect his emotional growth as an individual. If one could think of these faces as his visions of the first object, that which is usually called a breast in the jargon of psycho-analysis and that which is equated with the face, then one can see that he came into a world in which when he went to an object, from his point of view, it was weird and completely lacking in the reassurances which belong to the first experiences of most babies... At a significant moment, or in a sequence of such moments, he had reached out and nothing was there for him to find which reflected in any way his basic need, or his creative eagerness. It was as if he was drawing the picture of his own death which came after his birth" (p388).

Winnicott does not tell us the early history of this child but I wonder if a similar picture might be made by Linda at 13 years old.

Linda's first object after her birth was not a breast. It was a ventilator that kept her alive in the incubator. She was still connected to oxygen sitting on a chair. What impact does this sort of beginning of life have on the processes of projection and introjection? I worried that Linda's experience of a containing object would be powerfully coloured by this, both because of the facts of the case and because of her Mother's inability to come closer. It seemed that Kate found it difficult to get
close and stay next to such a baby. In the observation the baby was on the chair most of the time. When the baby had pneumonia two weeks after her birth and mother was told that it was "touch and go" mother left the Unit and went home. Two week later she went on a weekend holiday. Mother was in hospital for five weeks before Linda's birth. Kate was trying to believe that she had a normal baby who was just small. The fact that she was ill, very ill, was hardly faced. I thought that she could not get closer because of the unresolved unconscious conflict brought about by the birth trauma that pushed her back to earlier unresolved conflicts with her own internal objects (some of which are looked at in the second visit to the family later on in this chapter).

The studies I discussed at the beginning of this section describe difficulties of pre-term low weight babies of school age (The Lancet 1993, Paediatrics 1988). I think the lack of a containing experience in the early weeks of their lives when they were too frightening for their mothers, because they were so confused with damaged and damaging internal objects (Segal 1957), might have contributed to their later difficulties. In this case the pregnancy was the cause of the mother's very serious illness. The baby was therefore feared and unconsciously rejected, as well as being loved and cared for. I feel it is very important to try and understand and help, at the earliest possible stage, both parents in order to try and reverse a possible pathological process that might lead to pictures described by Winnicott.

The powerful ambivalent feelings of a mother towards a baby who was on the one hand very tiny and ill, and on the other the cause of the mother's very serious illness, and was viewed as a destructive attacker was clearly shown
in Kate's relation to her baby. This ambivalence is ever present in life on the Unit.

Jason

Another mother Mrs G, was a source of great concern to the Sister who visited her after discharge from the Unit and who had then asked me to see her. Mrs G had told the Sister that she was afraid that she would kill her son and was very worried that she would not be able to control her feelings.

I went to see Mrs G at home. I was struck by the feel of the living room: the methodical symmetry of the furniture, the enormous photograph of Mrs G's wedding that covered half the wall in the sitting room. Her wedding dress was of the same pink shade as her husband's tie. The furniture was all very carefully matching. A lot of thought and careful planning had gone into the everything. She told me how she had been in total control of her life until she fell pregnant with Jason. She took one big breath and talked non-stop:

"He came too soon, I was not ready for him, I wanted to have a baby, yes, but not yet. Well we did decide to have a baby but I thought it will take longer. I conceived when I was on holiday it was terrible; and then the birth! He came nine weeks early, I was not ready, his room was not ready, he was so ill, and I cannot even now put nice clothes on him. All my friends have babies but they are the right size. I am ashamed of him. I took him to my mother and I fed him and he nearly choked. I was terrified, I gave him to my mother and she managed to get him to burp, and he was OK again. I was so furious. I almost left him with her, I thought,"Right! If you can
handle him, you can have him, I am leaving!" But now I cannot trust her to look after him. I was also very little when I was born and I am an only child, my parents will do anything for me but I cannot let them".

Mrs G then told me that she did not want the Sister to visit her. I knew that she would only tolerate me for one visit. I talked about how Jason was resented because he made her feel that she had lost control, and the Sister made her feel little, as her mother had done. I said that she was furious, feeling an unsuccessful mother and wanting to get rid of the whole experience, by thinking of killing Jason.

Jason woke up and was picked up. Mrs G said "I do love you but I am so worried, I think only my husband understands and can feed him, I only trust him. He went back to work and I need him". I said that it was quite understandable that she felt that Jason's father loved him and would care for him and would not make her feel "light weight". I said that I would have asked him to take a few days off as she needed his help then.

I stayed a while, and she said she felt a bit better. I thought about her narcissistic need to be in control and of her rigorous and envious relation with her mother, this overspilling into her relation to the Nurses and the Doctors and to me. I was able to help her somewhat and report back to the Sister and Doctor what I had found and thought about Mrs G.

Segal in her paper "Melanie Klein: Emergence form Narcissism" (IJPA 1983 p269-277) describes narcissism as a defence against envy which serves to defend against a sense of dependence on an external object which is a
source of goodness. I thought that Mrs G's narcissistic relationship to her objects, and narcissistic character structure, were used as her omnipotence defence against envy of her mother. I thought that she was not likely to act her murderous rejecting wishes; she seemed to be able to reflect and take some comfort from her husband. He did not come across as a threat or a source of envy and therefore was able to help.

My visits and the thoughts it provoked were of some help to the staff who were very concerned for Mrs G. She had upset them very much as she had no doubt upset her mother. The Sister who had tried to help, was rejected, because being helped made Mrs G feel instantly small and dependent: feelings which she could not tolerate.

To Mrs G. Jason was a narcissistic blow. He was not the right infant, did not come at the right time or in the right way and was a source of shame and failure. It was possible to think that she needed a perfect infant and would have felt similar feelings had Jason come at full-term and had not been so ill. I received a message from her two weeks later, that she felt much better and did not need to see me again. The Consultant also reported a much calmer Mrs G.

A baby withdrawing into itself

Jack was another baby on the Unit, who had been born nine weeks prematurely, and was far less ill than Jason. His mother, Mary, had started to bleed at 31 weeks, had gone into hospital and had an emergency operation, and Jack was born two hours later. What was powerfully clear was how terrifying Mary had found the whole experience.
"I was told before that, if I bleed even little I am to come to hospital straight away...I was told this by my midwife and by my doctor. My placenta was a bit low, I was very very lucky and everyone was very kind". Jack was in an oxygen tent for three days and tube fed for about a week.

"I found it very difficult" said Mary, "when the doctor told me, that I had to produce milk. I could not and I got very tearful and very sore and I knew Jack needed my milk and I could not do it, the electric pumps were so difficult. A Sister saved me, she really calmed me down and told me forget about it being a mechanical thing, just do it a few minutes every three hours and gradually it came." She was talking while Jack was on her lap asleep and very still and warm.

Mary struck me as a very sensitive and loving mother. She was traumatised but was not cut off from the terror. She struggled ably with the support of her breast counsellor.

Jack started to stir after a few minutes. I was worried looking at him being so still almost as if he were dead. He was a big baby dressed in blue. His mother gave him to me as we went into the kitchen saying "here, do you want to hold him." My glasses got caught in his blanket and I felt uneasy. Mary made me very aware how frightened and guilty she felt. The somewhat unusual stiffness of the baby was striking, he was not curling into the mother's arms but curling into a ball as if into himself, or stiffly stretched out. (I often saw babies stretch in the incubator into thin air and think that in the womb they would have got hold of something perhaps, or have been restricted by the placenta.) It seemed that although Jack
was ten weeks old he seemed to give the impression of being alone.

Discussion

For the first week of his life in the incubator there was no breast available, no object to project into. It seems that Jack would need to be gently brought into contact with his object. Mary, I felt, would be there for him. Her guilt and terror did not develop into the "cut-offness" seen in the Kate-Linda interaction. I think that Mary was able to tolerate her anxiety somewhat better, either because she was more fortunate in that her baby was far less ill and, or because her "ego strength" was more available. I also felt Mary had "navigated" through the Oedipal conflict and had the sense that she had produced a baby. She was unhappy when she could not produce what the doctor had told her that the baby needed ie her milk, but she could help in the setting, and was somewhat reassured and gained in confidence in her motherliness. While she was unhappy and felt defeated, I thought that she was able to provide the holding and containing that were needed. Would Jack be able to turn to her, was what I did not know. She gave the impression that she was held by her own internal and external objects.

Follow up

I made further visits to see the two families. Kate was by then less anxious and was delighted in her daughter's putting on weight, being more active and obviously alive. She looked at her from a distance and did not pick her up unless she needed to. She said that she was looking forward to going back to work.
Kate's relation with her internal mother

Kate's phantasies about her relations with her mother were very clear when she told me, in my second visit, about her relation with her boss, a woman who was a cheat and a liar, who had used Kate's ideas to get herself promoted in the business while Kate had lost her job. The boss regularly pretended to be in the office, she used to leave the light on and her coat on her chair "so everyone wasfooled and thought she was there, but she was not."

I suggest that Kate herself felt fooled and cheated and left out of care and love when she was so ill. It was only when the danger to herself and the baby had abated, that she could even voice these ideas.

I thought the boss who cheated Kate and the organisation, stole her ideas to progress, while Kate lost her position, was a reference to the bad attacking and stealing and robbing internal object. She seemed less depressed. The experience of being cheated and fooled was safely locked into the work situation and I wondered if she would "explode" in frustration at work rather than be able to think and be in touch with her feelings about the "other bosses" namely the medical and nursing staff on the Unit that were felt to be powerfully in control of her and her infant's life as well as her internal "bosses" ie her parents. I was reminded of the experience Kate reported on the Unit in a parents' meeting about being told casually in the corridor by a passing doctor that it was likely her kidneys were too damaged for her to have any more children.

She made me think about work with post traumatic stress disordered (PTSD) patients who show irritability,
depression, sleep disorder and a hostile manner to others, for a long time after the actual trauma have gone (Gersons and Carlier 1992). I wondered how many parents in the Neo-natal Unit suffer from PTSD and go undiagnosed.

Mary’s relation to her internal objects

Jack’s mother, Mary, was also less anxious during my second visit. Jack was still on her lap all the time. She breast fed and held the baby who seemed to be restless, crying, eating and sleeping all within a few minutes, conveying the sense that he was uncomfortable and was persecuted by whatever was offered. (I also found this visit reassuring: Jack was demanding and was no longer still and stiff.) Mary was very patient and was worried about the long term effect of the previous weeks on her baby, and her relation with her husband. He seemed to be away a lot or to be very busy doing the decorating but not interested in his son. She said sadly that he was "ready to fall in love with his son, but then he came so early and was so ill. We really wanted him very much." Was she telling me about her husband’s feelings as well as her own perhaps, her disillusionment and sadness at not giving birth as planned. She seemed to feel let down by him and to have let him down. I worried that she might be "pushed" by these feelings to have another "good" baby and replace Jack very quickly.

Her relation to her mother was also somewhat fraught at the time. She resented the fact that her mother was upset and worried and expressed that to the staff in the Unit, saying "I am the one that should have been worrying and talking to the staff not her. I have no time to worry about her." The Childbirth Trust group too, were felt to
be not interested in her account. She said that it was "too grim, they just want good stories and did not want to listen to my story I could see how their faces became blank."

She struck me again as a sensitive woman who was struggling with feelings of being abandoned by all around her: partner, mother, N.C.T. She was very close to the baby and could not let him be away even for a second, as if she was trying to give the baby his fair share of being held by her in a compensating attempt to make up for the fact that he was not held inside.

**Ben's internal struggle**

On both my visits, Ben, Mary's husband opened the door and disappeared. I was told that he was decorating. Mary said that he worked very hard, all the time. It seemed that Ben was struggling with a sense of "unfinished baby" and was frantically trying by some manic reparation to improve the house, and with it the picture of his internal world. This was a very common story I heard in the Parents support Group ie the husband who was very busy decorating the house or fixing the car, after a premature birth. There were glimpses of a sense of being let down, felt by each of the parents.

I was told that he worked non-stop. Trying to overcome and decorate perhaps a painful or frightening picture he had about what sort of baby he had given his wife, how damaged was his internal "house" or what he felt about the baby his wife had given him.
Summary

Some premature infant observations have been reported revealing some of the difficulties the infants and their parents faced as their relations unfold. It is suggested that some of the "premature mothers" may have been suffering from PTSD (post-traumatic stress disorder) and needed a lot more help.

A premature baby's first object is not a breast. His first relation therefore is different from that of a full-term baby. I am suggesting that a systematic year's premature infant observation might shed some further light on this.

Some theoretical issues appear to force themselves on us such as:

what is the first object of a premature baby?

when does ego functioning start, if birth, which triggers this, is some 10 or more weeks earlier than normal?

These questions need further study.
7.4 A comment on psychotherapy with a boy who was a premature baby

Introduction

In the previous section of this chapter I tried to look at the object relation of a premature infant via some observations. Another possible source in understanding the nature of object relation of a premature baby is the material from therapy with patients who were premature babies.

My impression, based on talking to colleagues about my interest in this field, is that a number of psychoanalysts have in treatment patients who were premature, and who bring interesting material to their treatment that could be seen as related to their early life experiences. It is of course very difficult to say what is linked to the early prematurity and what to other difficulties. Only a research project, looking at transference and counter transference features of work, with this group of patients, might shed some light on this.

While hoping to have such a project one day, I detail below a short account of work with a borderline psychotic boy that made me wonder if his mental illness had started in fact in the incubator. The features of the early sessions that were most striking were "raw un-metabolised" experiences. It was as if he retained the sense of not having a containing object into which to project. Being "holed" and creating holes, and having a remarkable ability to create mess and chaos.
I wondered about being "interfered" with orally. He had been tube fed, he had also had help to breathe. His spontaneity in taking in air and food, from birth, had to be "organised" for him. I could not help wondering how it affected long-term spontaneity of looking for and taking in objects. He made a bigger mess in the therapy room than any other child I have seen or heard about. This area of his functioning did not have to be organised for him. It did seem to me that prematurity might be an indication of a need for psychotherapy in some severe cases.

About the psychotherapy with a 9 years old "ex Neo-nate"

Robert was referred for intensive psychotherapy at the Tavistock Clinic when he was nine years old. The referral letter talked about him lacking physical co-ordination and body control, unable to hold a knife and fork properly, wetting his bed, stealing from school and home, unable to fall asleep and said to be afraid of bad dreams. At school he was very disruptive, had no friends and had very poor school work and facial and hand ticks.

Robert had been born by a Caesarean operation six weeks prematurely because of his mother's diabetes and had been in an incubator for six weeks. He had been tube-fed for most of the time, and needed some ventilation.

Robert was a thin small boy, with attractive darkish features, the most striking of which were his eyes, both very bright and blank at the same time. Being with him felt like an extreme experience: terribly boring or terribly intrusive and disturbing. He made me feel that he created in the room violent scenes of "mess and slaughter". I met his parents who were both good looking and in their mid Thirties. Mother was very seductive in
her manners and so was Father. Robert's material made me think that a mass of infantile phantasies had been activated for the first time in his life and not relived, as if some basic aspect of first relationships had never been worked through.

**The first term of work**

The fact that Robert had been in an incubator for six weeks and also tube-fed came to my mind many times in the first term.

The recurring theme which he brought was "holes". Holes that were undifferented to start with, located up and down a plasticine wall which he created in a plastic container filled with water. After a while a pattern emerged, different size holes and a search for a "point" started. Robert said, while "feeling" with his hands the walls of the therapy room, that he was looking for a point to hang his string on to. He tried to stick the plasticine to the window and the ceiling and attach a string to it. The point he was searching for so urgently had a moving quality to it. Premature babies often "search" the surface of the incubator with their hands. Was this linked to the search for an object that we are all born with?

When he felt secure or somewhat contained he played near my chair, or curled up on the window next to me and listened for a few minutes. Towards the end of the session his mood would usually change: he would run away from me to the toilet on the way out, perhaps to evacuate completely the whole difficult experience of searching for a point, finding it and losing it again. Holes were made, which he stuffed, new ones created and stuffed.
I wondered, as I tried to make some contact, whether being tube-fed felt like being "holed"? His mouth had not been used when he was fed. A nasal tube had been used instead. I could not help thinking about the intrusiveness of a ventilating pipe into the lungs that pumped oxygen noisily into him, and what, if anything did it leave behind as a memory.

Second week in therapy--the sixth session

In the therapy room Robert took the plasticine from his toy box and put the bowl on the table. He sat and built inside it a plasticine "wall" dividing the bowl. He then poured water from the jug to one side of the plasticine "wall". He then told me "there are about 20 holes, most of them down one side, a big one, a "hofty-tofty" one." He smiled to himself, saying these words. I talked about how the first weekend might have felt to him, to have been a big "hofty-tofty" hole, or gap in his therapy, the first big gap that felt like a strange hole. Robert responded by making new holes with a pin from his pocket and blocked the existing holes with plasticine. I said that he was trying to block his ears; he told me "It will spoil my game." I wondered aloud about the feeling of holes being stuffed, new ones being created and how when he was a baby he had been tube-fed through his nose, not his mouth, and that he might have felt as if a new hole was made every time he was fed. (I was thinking about the perverse possible undertone of this activity of using new holes.) Inside the plastic bowl was one large plasticine wall dividing it, a few more lower walls and 2 marbles. Robert said "I'll make a wall for the cars to cross" and put the toy ambulance on the road. "There is a leak" he said, peeling a bit of plasticine from the bottom of the bowl and sticking it on the hole. He had made some water
black by melting a black painting block into it in a jug, and had stored his water in a bottle. He took this black water and poured it into the bowl and added a few more colour cakes to the bowl. It looked like a dead place filled with black water with cars/babies. The only things that were active are his fingers poking holes and stuffing them. I said that he was showing me a picture of blackness inside the bowl and inside himself.

It seemed to me to be an attempt of dividing/splitting the dead bad and black from something else and the dividing wall between life and death was full of holes. I thought that this internal good object was "holed" by the experience of being tube-fed and that reinforced his sadism. The "holed" object must also have some reference to the way he perceived his mother's ability to care for him and to stand up to his destructiveness and his later collapse. He struggled to achieve some splitting, and did not seem to be successful.

Robert threw a few more coloured cakes into the water in the jug and came to show me saying "this is nutty brown". I said that he felt the brown to be nutty, a crazy mixture of all sorts of colours. Robert said "yes, there is white, red, blue and black and brown."

It seemed that feelings like the colours were undifferentiated like the holes in the wall, and that made him feel that there was nutty brown stuff inside him, that no one could help him restore the colours. They were all mixed up. It seemed that there was a mix up, a confusion and no splitting, but the holes were more like sadistic attacks than a prelude for separate development.
After a lot of work on these themes of confusion, holes and feeling "nuts" it was encouraging to see over the weeks and months, some new development in Robert. From school came a report that he was able to start learning and make friends. The therapy lasted 18 months and the last I heard was that he had held on to some of the progress. Parents and Grandparents reported some pleasure at the new developments that were noticed at home too.

Summary

An attempt at looking at a pre-term baby's first object relationship has been presented via intensive therapy with a nine year old boy who was a premature infant. He was tube-fed and had to be helped with intake of oxygen. He made me wonder if his illness started in the incubator and reinforced his sadism and his belief that there was a holed, half-dead internal object inside him hopelessly mixed up with other dead or dying objects.

This would imply that his ability to split and differentiate had been weakened both by his prematurity and his relation to his mother. His mother was indeed ill. She was diabetic and her illness was the cause of the premature birth. I wondered if Robert was so disturbed by his history of being "controlled" that his spontaneity in taking in air, food, ideas was damaged. He could only expel and mess in a free way. It was possible to think that mother projected her own sense of being damaged into her infant. Therapy proved to be helpful. It seemed that the confusion was lessened somewhat; most symptoms disappeared. Robert was able to start learning and to make some friends at school. His reports improved and he was allowed to go on a week's holiday with his class.
7.5 Discussion

The inner world of a premature infant is a topic that has not been covered in the psychoanalytic literature. It seems to me that the terms "baby" and "mother" as used up until now refer to the full-term baby and mother. When the terms "birth" and "birth trauma" are used they refer to birth after a 40 week pregnancy. For example I think that Klein believed that "birth" and "breast" came together at one and the same time. In other words an object was available to the infant at the onset of postnatal life.

The works of other writers like Spitz, Winnicott and Mahler, imply the ordinary picture of birth, which is true for about 94% of babies in this country.

This is now changing rapidly. Babies that would not have lived 30 years ago now survive. With the rapid development of Neo-natology more babies will survive. The start of their life is profoundly different from that of the babies that psychoanalysis is referring to. Many babies live after only 25 weeks of pregnancy. This means that they start their post-natal life 14 or more weeks earlier than those which the great psychoanalytic thinkers wrote about.

This opens up the way to very interesting and difficult questions, some of which I have tried to think of, and look at via the premature infants I observed.
The impact of premature birth on the mother

We have some idea of the obstetric process that comes to a halt in the mother and the development that is interrupted in the infant in a premature birth. What of the emotional interruption?

If the whole last trimester of the pregnancy, or a large part of it, does not take place, what happens to the mother's maternality? Could it be said that she misses the depressive position anxieties and defences in relation to her baby? Could we think that the baby is therefore more confused with an internal ideal or persecuting object? Is the mother who is deprived of the full term pregnancy more prone to feel a pseudo-mother, hiding a terrible sense of not being a real mother and covering this problem up by idealising the infant and being scared of him? What happens to the sense of incompleteness, what and who does she identify with? and how would these issues play themselves out in the relation between mother and infant? Is this feeling projected by the mother into the baby who is therefore fated to feel even more incomplete than he really is?

I came to think of the mother as a "premature mother" and that in premature birth we find a "double prematurity" of mother and baby. The process of projection and introjection and identification must be coloured by the unconscious feelings of mother about being a premature mother.

The premature baby

The birth does not bring with it an object that can be projected into and introjected. There is usually a sudden loss of the uterus, and then a different environment. In
some cases a ventilator takes over and the baby is heavily drugged so as to prevent him from pulling the tube out of his mouth.

The ventilator keeps the baby alive. A drug is given that prevents him from pulling the tube out of his mouth which would cause his death. Is it possible to think that this impulse to get rid of the machine that pumps life and prevents death, is the expression of the death instinct? What gets drugged is the infant's built-in death instinct. If the infant is not provided with an object that can accept projection, then the infant will either not be able to metabolise the data, or will use his own defences, such as they are, to deal with the experience.

The first object

What is the first object of the premature infant, who has not had a breast available at birth? We could speculate that some process of interchange gets started in the womb. Is it therefore right to call the breast a first object or should we think of the "relation" between an infant and the uterus as the first object relation?

If this is the case what are the implications?

I think we could learn a lot about early object relation from a close premature infant observation which might enable us to see answers to some of the issues raised above, and the way the mother and infant struggle to resolve their difficulties.

-320-
We might see how the infant acquires an object, and a mother a sense of being a "real mother" belonging to the "parents' group" namely the mature grown-ups.

The number of premature infants is getting bigger and they are increasingly more and more premature (I was told recently of a baby who survived after 24 weeks gestation, and also of attempts, albeit failed, to save babies after 22 and 23 weeks of pregnancy). It might be possible for psychoanalysis to contribute some understanding of the type of difficulties the mother and infant have to go through, while undergoing premature birth.
Chapter 8. Discussion, Findings and future directions

8.1 Discussion

Introduction

This research project started as an attempt to solve a clinical problem. The problem, presented by the Director of Midwifery Services was the worrying difficulties of the staff on the Neo-natal Unit. My interest was fed by the fact that I had a border-line psychotic boy in intensive psychotherapy who, in his infancy, was a premature baby. Another clinical fact was the high level of referrals of toddlers who were ex-premature babies to the special play group in the Department of Child Psychiatry where I worked.

Below I present the findings of this work. I have divided them into two sections: structural/technical and psychological. The structural and technical part deals with the actions that needed to be taken for this research to get off the ground. The psychological part deals with the emotional data that came to light once the technical structures were in place.

Psycho-analytic research in a Neo-natal Unit.

The problems of working with a team were very interesting and difficult. A psychoanalytic background was essential but not enough. From such a background I brought with me some assumptions that needed to be discarded. I was used to the thought that if a patient comes to see me there is an agreement as to who the patient is, and who the analyst is: there is some agreement as to why we meet
and talk and listen to each other. There is a place, a
time and a language of ideas and concepts built over the
years that is there to be used.

These assumptions had to be discarded in the work on the
Unit. There was no agreement as to who or what or where
the "patient" was; no time or place or tradition of
meeting to think things through. The setting for work had
to be thought about and created.

A most useful tool for a psycho-analyst to get to know
what is taking place is get close enough to the emotional
environment to feel what is going on. It means that the
analyst is not remote observer but is a near one that
allows the feelings to influence him, and he needs to be
able to reflect on the interaction he was in some way
involved in and be able to think and make a useful
intervention. I tried to do this all along this project. It
is this aspect of the work that I think earns it the title
psycho-analytic research.

There are many difficulties in this way of work but also
great rewards. The use of insight, transference elements,
and many other factors had to be addressed in a different
way in a staff support group or a parents group compared
to work with a patient. The people I was talking to were
not my patients. I found that the response to what was
said could be very alive if it touched an emotional core
in the group. This could only be achieved by working as a
psycho-analyst.

The work in the Neo-natal Unit made me think that the
Tavistock consultant model might not be suitable for work
in such a Unit. I began to think that a different form of
intervention might be more appropriate. I want to look briefly at the technical issues of:-

1. Building a set-up for work

2. The approach and language used

3. A different model for intervention

4. Resistance to the work and work with resistance.

5. A need for diagnostic input into parental difficulties.

Building a set-up for work

The atmosphere on the Unit at the time of the crisis (which is described in Chapter 3) was that of cold disregard for people's feelings and concerns. There was a part object culture that spelled: one pair of hands is the same as another, a baby is a mouth or a hole that needs filling. This needed to change.

The process of changing this culture and building a set-up for further psychological work is described in Chapter 2. Having some idea of the resistance to work and change a gradual approach was adopted. It seemed that a staff group could not exist before some foundation work was done.

I started a Journal Club, a toddlers toy corner, contacted the parents via posters on the walls of the Unit and "humanised" the Unit with murals, plants and toys, all at the same time.
The Journal Club was an event where all the staff who were free came together to one room to hear a paper or a presentation. It brought with it the notion that we need to think and listen to each other, we do not know all the answers. Not being medically qualified enabled me to ask questions that needed thinking about. I also brought some speakers and papers; this role was later on taken by the Registrar and the Nursing Officer. The hierarchical structure of the staff was not maintained in the Journal Club. The event is still going on in the Unit.

The Nursing Officer reported a change in two areas; interprofessional relations improved, and mistakes were acknowledged rather than denied.

The toy corner was an attempt to "act a message" that spelled that the team was inviting in brothers and sisters of the babies to come to visit. The toys I brought were from home, old toys my children and friends' children had out grown. This was to say "we too have children", and also to try and minimise the notion of "them" - the patients, and "us" - the staff. Other members of staff began to bring toys, visiting increased, mothers brought their other children to visit.

The posters on the walls signed by the "Doctors and nurses of the Neo-natal Unit" emphasised the recognition by the staff of the unique contribution which the parents make towards the well-being of their babies. These big posters were read by everyone, new staff as well as new parents. This contributed to changing the culture in the Unit.

The Unit had a lot of plants that were in the corridor and some murals, prints and photos of babies that have grown up. The plants were looked after by the Unit Cleaner. I
encouraged her to put them in a public place so visitors could see them.

**The psycho-analytic approach in the Staff Group**

The people who worked in the Neo-natal Unit were not my patients, nor were the parents who attended the Parents Group I ran with a Sister. The approach and language in which to address them therefore had to be different from that which I might have used with a patient on the couch in my consulting room.

Nurses found the meetings useful when their emotional and professional concerns and experiences were addressed (Chapters 2 and 5).

Student nurses who felt deprived, lonely and angry at the beginning of their clinical work on the Unit were able to reflect, in a meeting we had, on my suggestion that similar feelings can flood parents and babies. Their empathy was available for some serious reflection when I pointed out that, unlike the babies or the parents they need not be overwhelmed by their feelings. It was possible for a staff group to recognise a process of identification that pulled them into becoming super-egoish or cynical beings (Chapter 4).

Plain English was used. Transference issues were noted only indirectly. The topics of discussions were chosen by the group from the most difficult cases or issues that were at the time, of concern to the group. Thus meaningful contact was achieved that lead to the staff and students feeling understood and in turn able to offer more effective help to their patients. The group was not the whole team. There was an acknowledgment that what was
discussed would be shared with other members of the team who were on duty or away at the time.

**Resistance to the work or working with the resistance**

Jaques shows us that resistance to change is fed by unconscious anxiety. His insight that feeds his intervention must be viewed as a threat to the organisation he sets out to change. I did not find much in the literature about the way people dealt with initial resistance to their input or what strategies were used to get through the first steps on the way into the institution.

Working with this phenomenon of initial resistance convinced me that a preliminary stage of the work had to take place in order to safeguard the future of the work. I found I had to try and build some suitable framework, find a right time and place that would be appropriate for the team.

The work with resistance on the Unit was very tough. People did not come to meetings, there was no one to ask what was going on. I felt a sense of unreality and confusion. I began to doubt arrangements that I knew had been made. In Chapter 3 I showed the steps I took before a staff group could start. One of the strategies I adopted was to go forward at a pace I thought the team would tolerate, and to stagger the work accordingly.

Once the work with the staff group started, resistance was located in the meeting like in any analytic work. I had to deal with a lot of observations that implied that what was said was at best irrelevant, or wrong and so on. I needed help at that stage of the project when it was not clear if
it would carry on. Writing down the data and discussing
it with colleagues was helpful.

A Model for intervention

Following Menzies Lyth's pioneering work with nurses I
attempted an intervention in the Neo-natal Unit. Her
work following Bion and Jaques, on the anxieties and
defences of nurses, was in my mind all the time.

Whilst using the ideas of the great thinkers I had to find
a structure and a language that suited this institution.
Building a set up for work needed a lot of thought and
careful preparation (Chapters 2 and 3).

A model for intervention in a Unit with severe on-going
anxieties was needed. I am suggesting built-in
psychotherapeutic help. A Neo-natal Unit needs Nurses and
Doctors and Cleaners and so on. A psychotherapeutic input
should be an integral part of staffing such an
institution.

To be the psychotherapeutic support for the staff and the
parents on the Unit was a tough and demanding job. I
wrote a paper and then started this PhD as a form of
gathering my thoughts and feelings. I thought that a
combination of therapeutic and research input was
essential. Writing this PhD helped my therapeutic work and
the therapeutic work benefited from some need to clarify
my thoughts.

The "Ego functioning" of the team was under constant
attack from the stressful job, the anxious parents and
their own personal mental state. The risk of becoming
concretely confused with damaged or damaging figures in
the Neo-natal landscape was a regular occurrence. I thought this process could sometimes be reversed if outside help was at hand, if not the team could and did get into difficulties. The cost of reversing this process in both time and money was much higher than having a built-in therapeutic input into the team.

The need for psychological diagnostic help on the Unit

Some of the parents of premature babies were also emotionally ill whilst on the Unit. Some came with a history of emotional problems.

I think a diagnostic service (be it of a psychologist or psychiatrist or psychotherapist) is necessary in a Unit like this to help the staff cope with paranoid suspicion, mania, depression, narcissistic thought disorder and post traumatic stress disorder. I heard about only some of the cases and it was difficult not to worry about them. Maybe the training of the Neo-natal staff should include some psychological input.

The usual attitude was to treat parents as if they were well, ie they had had a baby and that was a normal process, and it did not turn a mother into a patient. However that might be so in the majority of cases of normal delivery but is not the case in a Neo-natal Unit. Parents go through a sudden birth, they have a baby that is premature or ill or both. This fact produces anxieties sometimes of a severe nature. In the next section I look at the psychological findings of this work.
8.2 Psychological findings

Identification

Freud taught us that this process is at the centre of group life. Other thinkers, eg Bion, Segal, Sohn have shown us the minute and fast movement in this process. A team can identify with one aspect of the object or become identified introjectively with another aspect of the combined parental couple as an object. The process of identification can get "derailed" and be replaced by another more disturbing one (Segal's symbolic equation). I think that the crisis that brought me to the Unit was related to the team being confused with a dead or unconsciously murdered baby.

I think that the risk of the team being unable to mourn and being separated from cases on the Unit is ever present as I tried to show in two cases (Chapters 4 and 5).

When things go wrong and there is a breakdown of a team: there is a cynical devaluing of life, work and people, or a manic denial of facts. The project showed the way I dealt with this data.

The findings from the work of the Staff Group

The Staff Group meeting was an event that revealed some of the emotional difficulties staff faced and their defensive strategies.

Nurses have to deal with their own feelings about mothers who have premature babies. They might feel sorry for the mother or angry with her and her baby who will not get better making the nurse feel defeated and useless. They
can takeover and become "a super mother" in rivalry to the mother who might then feel even more inadequate. Some nurses have families and some do not have any children. Some can be pregnant while working on the Unit. These feelings were looked at in the staff group.

Very worried parents can be full of suspicions, depression or mania. They sometimes project their feelings into the staff, sometimes projecting their sense of not being able enough to be good or healthy or caring parents. The staff are then seen as uncaring or unfeeling and the Unit as a dangerous place for the baby to be in.

Nurses can be exposed to mania from other nurses. A parent desperately unable to tolerate awful news can sometimes bring an emotional storm that, like an "emotional hurricane" sweeps sense and facts away. Staff then begin to believe in omnipotence and denial. Facts are disregarded, a healthy part of the baby can be idealised, and no one wants to see and reflect on the truth.

Staff can go to a great lengths to try and collude with the manic mother who uses denial and idealisation in an attempt to flee the facts. Truth is so cruel that to hold on to it feels as if facing it or telling it is a sadistic attack on the poor mother.

Staff sometimes project their own sense of anxiety into the mother. A vicious circle than ensues and confusion sets in. It is difficult then to figure out who is more depressed or cannot face facts. I often felt that a need existed for a figure like that of the child in Hans Christian Anderson's story to state "but the Emperor has no clothes" meaning that this idea "had got no clothes"
or substance. Medical decisions are sometimes influenced by the omnipotence of all in the Unit.

When guilt, driven by omnipotence is on the increase a lot of work needs to be done for the team to return to some sanity. I tried to learn from these episodes. This sort of case came back again and again. I suggested in my meetings with staff that an effort should be made to be a little more prepared, more on guard in the next case.

The Staff Group work can be that of containing some of the feelings of the staff and even reversing an identification that was unconsciously embarked upon. I saw my role as that of the container into which the staff might pour their despair and other feelings. If we worked well together some relief was experienced and some hope and vitality restored. On these occasions some thinking could take place.

The focus of the Staff Group was not to try to help an individual nurse but to look at the group struggle with its work with patients and their families. It was in meetings of the Staff Group that some change in defensive strategies could be seen to take place. I do not know how long this can last without ongoing external psychological support. In my view the work with the staff must be ongoing.

The Premature Parent.

Perhaps an obvious finding of this work is the fact that the parents of a premature baby are themselves premature parents. They reach the stage of parenting the premature infant usually suddenly and earlier than expected. Some of
the mothers are ill and some have had to undergo an emergency Caesarean operation.

My impression is that these simple facts do not impinge sufficiently on the way the parents are treated on the Unit by the staff. It seems to me that the notion of the prematurity of the parents has not been thought about enough.

The parents are treated by staff as "normal" parents. They and the staff might be involved in an unconscious collusive interaction, where the trauma of a sudden birth and its implications are denied.

The emotional state of the parents usually goes undiagnosed. I sometimes think, as stated before, that a Unit like this needs some sort of psychological or psychiatric diagnostic service to help the Paediatrician orient himself in his contact with the parents.

Possible implications

The emotional implications of the state of being a premature parent were looked at in Chapters 5 and 6. It seems reasonable to think that if the pregnancy is incomplete the parents would have difficulties in believing the fact that they have produced an infant and that they are now parents. These difficulties might be covered up, the infant idealised and the phantasies about his imagined nature defended against.

Sometimes there is a strong sense of unreality on the Unit as if expressing the doubts that are half admitted:
are these babies alive? Will they survive? Are these people parents?

Parents of premature babies worry about their ability and "right" to be parents. They need an explanation as to what and why a premature birth has taken place.

The baby is sometimes treated with acute ambivalence. The wish for a "perfectly normal baby" drives mothers to become pregnant again very quickly. Some rejecting feelings are presented in the Parents Group. The baby is seen sometimes as a thing that can be replaced by another better one. Having one premature baby sometimes affects the wish for another child or the relation to the other children in the family.

Double prematurity

An area that interests me and which I would like to explore further is the nature of the relationship between infant and mother: how the mother gains the conviction in her ability and right to mother and how she deals with the sense of unreality that all that has taken place is just a facade. I often saw and heard parents express doubt about their sexual adulthood. Their persecution was projected into the Unit and its staff, who were felt to be extensions of internal conflict.

If both mother and infant feel premature and are indeed premature what sort of object does the baby introject, how does the mother cope with his projections? Can she project her own sense of prematurity powerfully into the baby? The parents feel ambivalence toward their infant who
is felt to be both frail and at times very frightening, attacking their trust in their adulthood.

They sometimes behave as if they are unconsciously looking for permission to be parents (Chapter 6 Section 6) as if the doctor or the team should approve of their parentality. I think in doing so they are externalising a disturbing inner conflict.

The "inner world" of the premature infant

The premature baby population is set to grow in numbers as Neo-natology advances. This population which did not exist 20 or 30 years ago starts life in a different world from the baby Freud and Klein wrote about.

This raises very interesting and maybe important questions. Klein's theory on early object relation presupposes an object present at birth, when projection of feelings and expelling of "bad stuff" takes place into this part object called the breast, as well as the taking in, introjection, of food and warmth from the object into the infant. If birth and breast are separated in time eg by some days or weeks, and the infant is fed by a tube and breathes with the help of a ventilator, will it colour his future object relation and if so in what way? His spontaneity of taking in air and food is totally "organised" for him at birth and for some time later. Will this interfere later on with his taking in of food, learning to speak and so on?

Could we think that the precursor of the processes of projection and introjection that Klein teaches us about starts in a more primitive way in the uterus. If that is so could we then say that the uterus is the first
object, providing the primitive first run to what the breast provides later.

Or to take Mahler's theory if the symbiosis stage of development is interrupted traumatically and prematurely, how will it affect the psychological birth?

A lot of premature babies suffer traumatic births. Tustin, Winnicot and others talk about the trauma at birth that might lead to a fall into psychosis or autism. Not all babies born prematurely become autistic. How and why do some avoid the fall into psychosis?

Struggle between Life and Death instincts

How is the ventilator that keeps the baby alive experienced by the infant? I think acute ambivalence towards it can be observed at the incubator. Babies often are seen trying to pull the ventilator out of their mouth. They are usually given sedatives to stop them doing this.

What is the force that makes a baby pull the ventilator out of his mouth? Could it be that this action is driven by the baby's death instinct.

These questions "forced" themselves on me when I was in the Unit.

Whilst I have some ideas about the difficulties of the "premature parent" the inner world of the premature baby is an area full of questions that I hope to look into in the next project.
8.3 The achievements of this project.

The original task of this project was to try and move the team from a "part object" world where one pair of hands is the same as another, where a baby is sometimes viewed as a mouth or a hole that has to be stuffed (looked at in Chapter 3) to a team that operates in the depressive position, where whole objects that are different and separate from the subject are known. Where reality, both internal and external is acknowledged and tolerated.

The steps along the way to meet this task is the story of this thesis.

The early work of starting a Journal Club, a toy corner for the siblings, and a poster campaign aimed at parents brought with it some change in the cold atmosphere of the Unit.

A better relationship between the disciplines was noted by visiting professionals ie health visitors, GPs and people from other Units. The parents started to make comments such as "staff here are special, they are hand picked and they care about you."

With the containing experience that the work with the staff group provided I show a gradual move to a more "whole object" world where some separateness was achieved with some ability to acknowledge facts, mourn, and face reality.

As staff began to feel more "together" their own goodness is reinforced by introjecting an experience of there being a containing experience for them in the staff group meetings and many other informal occasions. There was a sense that it was a good Unit to work in. Individuality of
nurses and babies and parents was more and more acknowledged. Staff interest in the various aspects of this work was and is encouraged. For example, one member was interested in new work on ventilation and another on the control of pain in the premature infant. Their findings were shared with the team in the Journal Club.

The Nursing Officer noted that mistakes were acknowledged rather than hidden. With some satisfaction she reported that there was a sense of a team in the Unit. People helped each other and shared the same beliefs and targets. It meant that people did more than they were contracted to do, and they knew what was needed in an emergency without being told or asked (Chapter 3).

The national average time that nurses stay on a Unit like this is eighteen months to two years (personal communication from the Nursing Officer). In this Unit however there is a core group of about ten to twelve nurses who have been on the Unit now for more than ten years. The Unit has undertaken more difficult work with more seriously ill babies. Some members of staff have published papers in a nursing journal and some are training in counselling skills which they bring to their work with the parents.

Curiosity and interest in my work on the Unit was noted when I gave a paper to the Applied Section of the Institute of Psychoanalysis on the Change in the Defence System in a Staff Group of a Premature Baby Unit. Both Consultants and Nursing Officer of the Unit came and took active part in the discussion. One Consultant expressed interest in joint research in the follow-up of premature babies with myself and other analysts. My ideas on the prematurity of the parents have been taken up by the
Paediatrician and the nursing staff as a useful in their clinical thinking about the families of the patients.

Another indication that this work is valued can be seen by the fact that my hypothesis is now part of a research project. The Senior Registrar in Child Psychiatry, the Consultant Neo-natologist and myself will look at the episodes of post traumatic stress disorders in mothers who gave birth after 30 weeks of pregnancy.

The Unit is a source of pride for the hospital. The decorations of the corridors with murals and plants and posters is a source of interest and satisfaction. The team now runs an annual study day on aspects of Neo-natology inviting outside speakers and providing some speakers from the medical and nursing staff on the Unit: this is a very well attended project.

The traditions that have been developed in this Unit of Staff and Parents Group work have passed on to at least two other hospitals. The Consultant at another hospital, who was a Senior Registrar in this Unit took with her our tradition. In a recent professional meeting she said that she will no longer be prepared to run a premature Unit without the psychological input that is provided in our Unit. She said "You would miss too much data, if you did not have this input into the work." Another colleague found this concept very useful in her work and introduced it to another of the London teaching hospitals.

The development in the staff as a result of the containing experience

At the beginning of this thesis I report on a death of a baby that made me think the nurse experienced the way it was handled was as if she had been forced to join a Nazi organisation where the meaning of life and death was
denied, and meaning and feelings were prohibited (Chapter 3, second observation).

The containing experience that I provided in the staff group as reported in Chapter 4 increases the staff's ability to accept reality and mourn the loss of Mrs S's babies (4.4).

The staff ability to think developed as they introjected this containing experience. The case of the heroin addicted mother, shows the change in my role, which was to provide the set-up where the thinking of the staff takes place. It is their ability to think and feel and express all this that has grown, thus showing the ego strength shining through (4.5).

The care of the parents:

It seems that since the start of the work with the parents there is some sense that they feel more supported. We provide a time and space that acknowledges their experiences. We listen to them and they listen to each other (Chapter 6).

They started a lively parents' committee that helps the Unit. They raise funds for medical equipment and organise social get-togethers of "ex Neo-natal" parents and their children.

Last Christmas saw a group of a hundred parents and their toddlers who were "ex Neo-nates" come together on a cold and wet Sunday afternoon in the social club in the hospital. They celebrated, showed their growing children and donated money to buy an incubator for the Unit.
The organiser of this activity and others like it, is one of the mothers (discussed in Chapter 5). Her baby, who nearly died, is now a lively toddler. It was very moving for me to see all these people two or three years on together with their children and hear about their present preoccupations.

I was invited into the Unit to help solve a clinical problem, I did this but then stayed to discover new issues that needed looking into. Helping solve these problems made me feel that I was doing something good which is a fundamental need and is a part of human nature. Other people get the "message" that it is OK and move in the same direction, doing things in their way. Parents help other parents and staff and their friends and relations do the same.

The Unit now sees its task not just to repair the babies but to care for the babies, their families and each other. Put in a theoretical way it seems to me that the ego strength of the Unit has gained a lot and there are activities that are now able to take place without involving me, for example the development of new relation between a parent and a named nurse. Cases are assigned, staff get personally involved and get to know their babies and their families. Mothers and fathers are encouraged to care for their babies as much and as soon as possible. They bath and feed tiny babies. Infants of 29 weeks or less are being breast fed, and as long as they are stable they come out of the incubators for a cuddle or "Kangaroo care" inside the mother or father's shirt.

Parents visit and stay as long as they want to, day or night. They are encouraged to visit or phone 24 hours a
day. They do. It is seen today by most parents as a caring Unit.

We are also able to reflect and tolerate parents' sense of rejection or failure and their ambivalence towards the Unit and towards their babies and each other. These negative feelings are somewhat more openly discussed in both Parents and Staff Group meetings (examples in Chapters 4 and 6).

My role has changed from being a figure that needs to be rejected as a source of dangerous new ideas, to someone who is part of the team. I have been told on many occasions that "I am part of the furniture of the unit". I would suggest that what I stand for has become part of the furniture of the unconscious and conscious culture of the team. I think a project like this can no doubt be repeated elsewhere and my work offers some guide-lines although I think another researcher will have to map in detail his or her own way of working.

Limitations

The collecting of data (Chapter 2) was very slow. Building the framework for work also took a long time.

It could be argued by purists that the roles or "hats" of observer, researcher and therapist, do not sit comfortably on one head. On the other hand having several hats/roles made it possible for me to carry on the work.

This was a research project that had its origins in the need to solve a clinical problem. As such it might be said it was not pure research. It was more a clinical problem solved via psycho-analytic action research and producing further areas that need looking into.
It could be argued that it is difficult if not impossible not to be biased. As a psychoanalyst working on a research project I tried to use my feelings and understand what provoked them. This in turn enabled me to get close to the emotional truth of life on the Unit which in turn enabled me to intervene at times effectively.

8.4 Future Directions

1. A premature mother and infant observation

Following what was said in Chapter 7 about the premature baby's early life I would like to start a project that might help me understand this somewhat better.

The double prematurity, namely that of the infant and of his mother who reaches her maternal role prematurely and the way this phenomenon unfolds and influences the relation between them can, I hope, be looked at in an infant observation.

Prematurity, or "incompleteness", affects or might affect, the contact between mother and infant. It is possible that an "as if" sense in the mother about herself as a mother meets with an "as if" sense in the baby.

The projection and introjection of these painful feelings might contribute to the nature of the mother-infant contact. It would be interesting to think about the nature of the object that the baby introjects and identifies with and what does the premature baby means to the mother. If mother suffers from a sense that she is not a "real mother" who gave birth not to "a real baby" the object that the baby has to deal with will be coloured by these issues.

-343-
I hope to look once a week at an infant born after 25/26 weeks gestation and follow him and his mother in weekly observations for a year. How the baby and mother overcome their difficulties and develop a sense of "maturity" and a sense of trust in their liveliness and the liveliness of their internal objects is another area that I would like to look at in this premature infant observation.

Some of what I might learn I hope to share with the staff on the Unit. The Journal Club I started years ago still meets every Friday and might be the right set-up to look at what I might find. I think that people might be interested to consider the impact of a double prematurity on the baby's development. The parents' emotional trials need to be more carefully looked at by the Paediatrician and the Neo-natal nurses.

Possible link between prematurity and "modern" illnesses

The oral phase of development of the premature infant is characterised by the following phenomena: his spontaneity is "interfered with" and is "organised" for him by the various machines like ventilators and tubes. Breathing and taking in feeds cannot be done by the baby alone.

I wonder if there might be a link between the increasing number of premature babies who survive and an increase number of young children who develop breathing difficulties like asthma, feeding disorders like anorexia and speech difficulties.

Are feeding, breathing and speech disorders that might appear a year or two after birth linked also to the length of time the baby was ventilated and tube-fed?
Working with the Developmental Paediatrician who monitors the babies discharged from the Neo-natal Unit I will try to look at the possible link between the two "modern" facts ie an increase in premature baby survival and an increase in the children who suffer from "orally centred" illnesses.

3. Emotional Difficulties of the "ex-premature baby"

A borderline psychotic nine year old boy I saw for psychotherapy, who had been a premature infant, made me wonder if his illness started in the incubator? Was his prematurity a contributory factor to an inner world that was revealed in his treatment as very bereft of an object that could provide a holding and containing experience? I could not be certain.

I would like to see if the number of "ex-premature" babies who present themselves in Child Psychiatry a few years after birth with some emotional symptoms, is larger than their number in the population as a whole.

With the help of members of the team of Child Psychiatry in the hospital who showed interest in the project, a few questions about the child's early history would be asked of the child's mother. We hope to look at all the children referred to the Department in the next year. The present difficulties of the "ex-premature" children would then be looked at, and an attempt to think about a possible link will then be undertaken between their early history and the current pathology that brought them to seek help.
4. The premature mother

Some of the difficulties of the premature parents are looked at in Chapters 5 and 6. Together with a Senior Registrar from Child Psychiatry and the Consultant Neonatologist we hope to start a research programme that will aim to find out in some detail what are the difficulties of a premature mother. In the first stage we hope to find via interviews and questionnaires how many mothers who gave birth after 30 week pregnancies suffer from Post Traumatic Stress disorder. This project has already started with the support of both Paediatricians and the Child Psychiatry department in the hospital.
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