

Premature Mothers of Premature Infants – a Relationship Trauma

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Abstract: Literature focusing on the intrapsychic development of the mothers to premature infants is not as extensive as reports dealing with medical and developmental risks for the infants. Given the importance of the qualitative aspects of early relationships for a child's later socio-emotional development, the understanding of maternal intrapsychic development during pregnancy and the infants' first year is of interest for clinicians working in families with premature infants. The trauma of an interrupted pregnancy constitutes a psychological risk for emotional disturbances threatening both the well being of the woman, her care giving capacity and the relationship with the infant. This paper deals with psychological aspects of pregnancy development based on a psychodynamic theoretical frame, and discusses the creation of representations about the infant and the formation of the mother infant relationship, as well as the structural development of a maternal role identity. In a case vignette the therapeutic work with a mother and her premature baby illustrates some of the problems a mother has to work through in order to develop her motherhood mindset.

Zusammenfassung: *Frühgeborene Mütter von frühgeborenen Kindern – ein Beziehungs-trauma.* Die Literatur, die sich mit der psychischen Entwicklung der Mutter in Zusammenhang mit einer Frühgeburt beschäftigt, ist nicht so ausgedehnt wie die Berichte über Risiken hinsichtlich medizinischer Probleme und der weiteren Entwicklung der Kinder. Wenn man von der Wichtigkeit qualitativer Aspekte der frühen Beziehung für die spätere emotionale und soziale Entwicklung eines Kindes ausgeht, dann ist das Verständnis der psychologischen Entwicklung der Mutter während der Schwangerschaft und während des ersten Lebensjahrs des Kindes für die Kliniker von Interesse, die mit Familien mit frühgeborenen Kindern arbeiten. Das Trauma der unterbrochenen Schwangerschaft stellt ein psychologisches Risiko für emotionale Störungen des Wohlbefindens der Frau, ihrer Fähigkeit für ihr Kind zu sorgen und für die Beziehung mit dem Kind selbst dar. Dieser Beitrag beschäftigt sich unter Bezug auf ein psychodynamisches Verständnis mit den psychologischen Aspekten der Schwangerschaftsentwicklung und diskutiert die Ausbildung von Repräsentanzen über das Kind, die Entwicklung der Mutter-Kind-Beziehung und die strukturelle Entwick-

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lung der mütterlichen Rollenidentität. Ein Fallbeispiel der therapeutischen Arbeit mit einer Mutter und ihrem frühgeborenen Baby illustriert einige der Schwierigkeiten, die eine Mutter zu bewältigen hat, um eine sichere Mütterlichkeit zu entwickeln.

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In recent years, there has been a technical revolution in neonatal intensive care and the number of surviving infants born very prematurely or with very low birth weight has dramatically increased in Sweden, as it has elsewhere in the industrialised world. Before 1940, no medical treatment was given to prematurely born infants and the only recommended intervention was to keep the infant warm, either by warm bottles or, if available, in an incubator. Many infants were cared for in the home by their mothers since little could be done in the hospitals. Home care facilitated early contact between mother and infant, something we today know promotes the attachment process, although the quality of the relationship was at the same time probably negatively affected by the perceived threat of loss, the death rate during the neonatal period amounting to almost 70% (Stjernquist 1992).

When incubators were first developed in Germany at the beginning of this century they were exhibited at fairs together with premature infants. The infants were taken care of by trained nurses. However, when the exhibited infants had grown big enough to be replaced, some of the biological mothers were not interested in having their infants back. The development of the relationship between mother and infant was disturbed. The mothers had not expected the prematurely born infants to survive, they had given them away and had already mourned them (Klaus and Kennell 1976). Even in the 1970s, when improved neonatal technology first made it possible to treat prematurely born infants in hospital for longer periods, the effect of mother-infant separation on the development of early relationships was not in focus. Parents came to visit the infant at the neonatal care units (NICU) once a week, or if living far away even more seldom.

Today technical advances have created a situation in Sweden where the survival rate even for the smallest infants, i.e. those with a birth weight under 1000 grams, is over 50% (Stjernqvist 1992). Well-equipped regional hospitals can offer perinatal obstetric care and supply continuous infant monitoring after delivery, with special care for ventilatory and circulatory support, respirator therapy, medical therapy and energy supply as well as neonatal paediatric surgery. Many prematurely born infants spend up to one third of the pregnancy period in a highly technical environment outside their mothers body. Gradually, hospitals have changed their routines for parental involvement. Today medical staff at the NICU support parents in holding the infant and participate in the care. The "kangaroo procedure", where a parent holds the infant skin to skin is encouraged in many hospitals, both to support the attachment process and to give the infant tactile stimulation, valuable for the further development of the brain and the ability to cope with stress. Parental handling is believed to have a deeper amodal affectionate shape than the more task-oriented handling by the nurses (Alves Attree and Adamson Macedo 1997). However, the question remains. How is the quality of the relationship between a mother and her infant affected by the premature birth?

The psychological growth of a child is today often described within the attachment theoretical framework (Ainsworth 1982; Bowlby 1969). According to the attachment theory, the quality of the early experiences of care is related to the child's later emotional and cognitive development. Maternal well-being is one of the cornerstones since the caregiver's sensitiveness and capacity to meet the infant's needs creates the secure base from which the child develops. Studies have shown that early interaction patterns differ between preterm and fullterm mother infant pairs (Field 1980). Prematurely born infants are more passive and parents tend to compensate this with an increased level of parental activity. Further, parents might want to compensate their infants for the separation after birth with more behavioural involvement and social stimulation (Risholm Mothander 1998).

It can be concluded that the physiological survival and the health of the premature infant has been the main focus of perinatal research in recent years, and efforts have been very successful. More families than ever before have surviving children born before term. But has the interest been more focused on the situation of the infants than on that of the mothers? The physiological implications of the premature birth seem to have been more discussed than the psychological consequences. In recent psychoanalytic literature not much has been written about the psychological understanding of the increasingly common female life event of having a child born too early. How can modern psychodynamic theories about the development of the maternal identity, and the formation of the first relationships be applied to the understanding of the psychological effects of a premature birth. Raphael-Leff (1991) writes "The pregnancy does not only have the aim of producing an infant but also a mother". How can we understand what is happening psychologically in a mother-to-be whose infant is born dramatically, and often unexpectedly, in mid-pregnancy? How is she to psychologically cope with the infant developing outside her body for almost half the pregnancy, taken care of by experts using highly technical devices in an environment more similar to an aeroplane cock-pit than a nursery, let alone a womb? How do these circumstances affect the development of a woman's motherhood mindset, her bonding capacity and her ability to care for her offspring?

The development of a maternal identity has been described as a process extended in time. Freybergh (1988) has characterised the psychology of parenting as an emotional process with no beginning, a process starting many generations back. In psychodynamic family therapy literature this psychological heritage has been described by Byng-Hall as family-scripts, a set of family rules and expectations transferred from one generation to another, guiding younger people as to what parents are like, how to take care of children etc. (Byng-Hall 1995). Grounded in classical psychoanalytic theory Lebovici writes about the "fantasy baby", a baby that reflects the deepest and earliest layer of the individual's reproductive drive (Lebovici 1984). The "fantasy baby" is, according to Lebovici, created by unconscious material rooted in the preoidipal symbiotic relationship with the mother. The "fantasy baby" is both mother and child, existing in an early narcissistic state where all needs are fulfilled. The individual's experiences of having been in this state constitute the emotional base in a future parental identity. In view of writings by Risholm Mothander (1994), Stern (1998) and others, the metaphoric "fantasy baby", can be seen as a precursor to the development of the "imagined baby".

The psychological preparation for parenthood starts early in life. When the child, at the age of two to three, has established a gender identity, she or he can look around and see that girls become mothers and boys become fathers. Inner thoughts, representations and working models, are created about how real mothers and fathers behave. The relationship to a future infant of her or his own is still on a narcissistic fantasy level, although the child is gradually getting used to the idea that it takes two to make three. During adolescence the relationship to the reproductive capacity is further developed and differentiated, women become mothers and men turn into fathers. Finally, at conception when a woman becomes pregnant, the infant-situation becomes reality. The physical and hormonal changes of the body push the psychological development forwards. Stern (1998) writes that there are three pregnancies going on simultaneously. The physical foetus growing in the woman's body, the motherhood mindset growing in her psyche and the "imagined baby" taking shape in her mind.

When a woman has become pregnant her first psychological task is to accept her pregnancy. She has to deal with her ambivalence, based on the narcissistic wish for an infant of her own in conflict with the fear of responsibility and lack of freedom. She has to work through the mourning of the non-maternal life and give room for expectations about her future life. Her pre-oidipal "fantasy baby" has to develop into an "imagined baby" to whom she can create an object relation. When the mother-to-be, at the quickening, can feel the presence of the infant in her body, mental representations about her infant and herself as a mother are stimulated and she develops an emotional state in which she can actively prepare herself for the meeting after birth with the "real baby".

The literature on maternal representations during pregnancy is growing. Attention is being paid not only to the content, the richness of the representations, but also to the pattern of coherence (Ammaniti et al. 1992). The attachment pattern of the woman, based on her own childhood experiences, is thought to influence how she will use her pregnancy to work through the relationship with her own mother, and reach adaptive solutions to her wishes for a child to fulfil her needs. The process of creating and elaborating representations is believed to dominate the period between the 5th and the 7th months of pregnancy (Stern 1995). Stern (1998) writes that a woman gives the freest rein to her imagination during this period, but that the two last months are characterised by the undoing of the earlier constructed "imagined baby". This undoing is a preparation for the meeting with the "real baby".

Many prematurely born infants are born in the 6th to 7th months of pregnancy. This is a situation where it is not only the infant that is premature but also the mother. In the classical psychoanalytical view, as interpreted by Deutsch, the unborn child is not yet an object to the mother but a fantasy product in the mother's psychic life (Deutsch 1945). She writes that the baby is only an object in the future and "how can I love something that does not exist?" (Deutsch 1945, p. 158). Leon (1996) has in his paper about perinatal loss, discussed that pregnancy loss or neonatal death is to be viewed as a frustration of wish rather than the loss of an object relation. He argues, that considerable empirical and clinical data today indicate that during the last trimester of the pregnancy the unborn baby is more and more experienced as a separate person to whom both parents can have an object

relation. Leon's arguments can be transferred to our discussion about premature birth-giving. If the expectant mother has felt the foetal movements and if she has had an ultrasound or a sonogram examination she knows there is an infant inside her womb, not a fantasy. However, only the contours of the infant are outlined. The earlier in pregnancy the more vague is the picture. In interviews with pregnant women made by Ammaniti and his colleagues in Italy, 30% of the women thought of the foetus as a person during the first trimester of the pregnancy. During the second trimester the figure was 60% and during the third trimester it amounted to 90% (Ammaniti et al. 1992). Together with her developing "imagined baby" the pregnant woman is in her representational world playing a game where the unborn child and the mother-to-be are given different roles in order to act out different future scenarios where the relationship can be tested. In this game, the mother is afforded a mental opportunity to work through her earlier nurturing relationships and rewrite her family scripts to create room for a new role as a mother to this particular baby.

This intrapsychic and interpersonal game between a mother-to-be and her unborn child is suddenly interrupted at preterm childbirth. When the infant is born unexpectedly early the play has not come to an end, it has just started. The first contours of the "imagined baby" might just have been depicted and the formation of an object relation be under way. A new situation is at hand, with a physically vulnerable infant, an unprepared woman who has not yet fully developed her motherhood mindset and a "fantasy baby" in the process of developing into an "imagined baby" who does not yet correspond with the "real infant". In this situation the mother is forced to hand over responsibility for the infant's survival to the medical experts in the hospital. The NICU staff will have to do what the womb has done until now, i.e. create a nurturing environment for the physical part of the pregnancy to continue. However, at the same time as she is sharing the infant with the NICU staff, the mother-to-be has to continue her own part of the game, the development of the motherhood mindset and the formation of the relationship with the "imagined baby". Research has shown that the quality of the relationship between the mother and the NICU staff is of great importance here. If the mother is going to bridge the pregnancy interruption and allow herself to continue her intrapsychic development she has to trust the hospital to act as her uterus (Negri 1994). If the mother can idealise the hospital and identify herself with the NICU staff she can more easily allow them to carry on the "physiological pregnancy" and postpone the psychological reactions to the trauma of having a preterm delivery until the infant is allowed home. In the home environment it is easier for her to loosen up her defences and let the relationship with her living "real infant" guide her through the trauma. However, if the mother cannot feel the NICU as a safe place for her infant, the affective involvement might be disturbed and the formation of the relationship with the infant at risk. The complicated situation of coping with a premature birth giving implies that mothers need a qualitatively different psychological support when the infant is still at the NICU, than what is needed later when the infant is allowed home and they are to meet and interact on the "real baby" level.

In a case vignette, I would like to illustrate a traumatic break in the pregnancy development caused by a premature birth. The case deals with a mother born

too early, a mother who did not have time to work through her ambivalence and develop positive expectations until the infant was born. She could not establish an emotional working alliance with the NICU staff and trust them, but had to develop her motherhood mindset on her own with the infant outside her womb and in her care. The imagined baby was not allowed to develop but was too early turned into a vulnerable and demanding real infant.

Adam is not a planned infant. Both his parents are musicians in their early thirties. They have known each other for a couple of years and have just moved into their first home when Anna becomes pregnant. Their job situations are not stabilised, they work as free-lancers but are optimistic about the future, both being at the start of promising careers.

Anna is the only child of her family. She has a complicated enmeshed relationship with her mother who is an immigrant from a central European country and very dependent on her daughter. Her father died when she was 14. She says that both her parents are still invading her and she is working hard to keep them out of her life. She falls in love with Thomas because he is not intrusive. Thomas is the youngest of three children, with two elder sisters. He has a relaxed attitude towards life and Anna says he brings joy into her life. Soon they are planning a life together. Anna is very careful not to get pregnant and she remembers exactly when she conceived, blaming Thomas for not taking enough care. They have a serious discussion about abortion but Thomas persuades Anna to keep the child, he wants to have a family and promises to take an active part in the care of the infant. Anna is ambivalent, but since they are a couple and since she also wants to have children, only not now, she agrees to have the child. Anna does not feel well during pregnancy, she has morning sickness, she feels invaded by the infant, but tries to stave off the pregnancy by concentrating on her work with the symphony orchestra where she has a contract for the season. In the 25th week of pregnancy she becomes very ill with pregnancy toxemia and is admitted to hospital where Adam is delivered two days later. He is small but does well at the NICU. Anna needs two weeks of hospital care to recover from her illness. Adam stays in the hospital until full term.

Anna visits Adam at the NICU every day and participates as expected in the care of her infant. However, she does not socialise with other people on the ward. She does not make friends with other parents, nor does she get close to any of the staff. She says the staff are efficient but not really her type of people. She is not emotionally involved in the care of the infant, but plays the role of a good mother so that nobody notices her. Later she can see that during this period she was not aware of what was going on around her. The dominant feeling is her anger towards Thomas who she makes responsible for placing this monster in her body, a monster which almost killed her. She feels caught by the infant, an infant she did not want and who is hindering her professional development. Someone else has taken her chair in the orchestra. To her surprise she feels punished by the infant and blames herself for having concentrated more on the music than on the pregnancy. Anna cannot understand why she has feelings of not being a “real woman”, and she fears that she will never enjoy babies the way other women do. She hides her psychological predicament when visiting the NICU, no one in the hospital notices her depression.

When Adam, at full term, is discharged from the hospital Anna's ambivalence is triggered and she cannot handle the situation herself. She thinks she is going mad and looks for psychological treatment. Anna wants to take care of the infant but at the same time wishes he was dead. She does not like what she calls the biological part of her person, the part that is occupied with the survival of the infant. Her body wants to breast feed, her sleeping pattern has changed and she listens to the breathing of the infant at night. Anna is forcefully resisting getting involved, she hopes Adam will leave her alone by sleeping long hours. However, in a mechanical way she does take care, Adam is well fed and looked after.

Anna is still very angry with Thomas and their relationship is at risk. Soon after Adam is discharged from hospital Thomas is offered a 4 months job in a town 500 km away. He wants Anna and Adam to come and stay with him but Anna declines.

Ever since coming home Adam has been an easy infant. He needs frequent feedings but in between he sleeps well and is not a fussy infant. It is as if he cannot push Anna to hard, as if he must allow her to concentrate on her inner development and remain in the womb. However, Adam becomes a low-key infant. His first smile is delayed and his mood is predominantly sober. The infant grows, although as with many babies of depressed mothers Adam seems to adapt to his mother's mood. Anna is actively withdrawing from her own mother, not talking to her, nor seeing her. Thomas is not there to compensate Adam for the lack of positive maternal affect.

In the mother-infant therapeutic contact, lasting about a year, Anna deals with her ambivalence about having an infant. She sorts out the past in order to meet the future. Anna is working through her feelings of being invaded by others in order to be able to meet herself as a mother. The "imagined baby", the intruder who also almost took his mothers life, is developing into an infant that corresponds with the vulnerable infant boy she has. Over the months Adam is growing, gradually demanding more of his mother and when he is about a year old Anna can accept being mother to Adam. She can meet his need for close contact and enjoy his exploring excursions in the outer world. Thomas, has returned home and they start going to marriage counselling.

To summarise, when a premature infant and a premature mother meet, not only is their health at risk but also their relationship. In order to avoid a preterm birth developing into a relationship trauma that may have long lasting effects, both mother and infant have to be taken care of in an integrated physiological-psychological way both at the delivery hospital and when the infant is discharged from hospital. The mother is forced to place her preterm infant at the care of the NICU, but the staff must also be aware of and understand the importance of creating a good relationship with the mother, not demanding too much but convey the message that the infant is safe at the NICU. If this is achieved the mother will not merely feel forced to act but will also be able trust the staff to take care of the needs of her infant. If she can do so she can more easily continue the psychological processes of her pregnancy. In order to become a full term mother she has to go on developing her motherhood mindset and prepare herself to care for the real infant, the infant comprising the "fantasy infant", "the imagined infant" and the vulnerable preterm "real infant".

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