

A Premature Meeting Mother-Baby-Kangaroo: Building and Repairing a Relationship

Hilda Botero C*

Emotional Care Advisor in Newborn Units and Kangaroo Programs, Bogotá, Colombia

***Corresponding Author:** Hilda Botero C, Emotional Care Advisor in Newborn Units and Kangaroo Programs, Bogotá, Colombia.

Received: February 21, 2020; **Published:** July 30, 2021

Abstract

When does the emotional experience of motherhood begin to operate? Although the physical data is palpable, the emotional event is less obvious, but no less intense, nor does it present less revolution. Without a doubt, pregnancy raises in women, and in men, a different mental organization. The woman who begins her pregnancy plunges into a special world of sensitivity and attention.

Keywords: *Premature Meeting; Mother-Baby-Kangaroo; Building and Repairing; Relationship*

Let's take a look at the most special moments of pregnancy. Each quarter, broadly speaking, entails anxiety and its own fantasies. At the beginning, with nesting and placentation, anxieties are emptying and at the same time, terror is invaded by something, or someone unknown. Ambivalence will be present, now, with a special emphasis, and will remain throughout pregnancy. The body is the one that, in an evident and concrete way, communicates this mental state, given the impossibility of making the perceptions of the internal processes conscious. Recurrent symptoms such as hyperemesis, constipation, diarrhea, throw us knowledge about ambivalence. This is based, either on the fear of having something that damages from within the body, or already on the fear of unknown experience, an unknown being, so the tendency is to take it out, expel it, and at the same time, to accept and willing for a child as a loving contained.

The second quarter is bound by more accurate data on pregnancy; fetal movements cause different somatic symptoms and affective ideations of damage, kicks that will spoil organs. Another alternative is a baby that mother doesn't feel, that doesn't manifest himself. The container of fantasies is told according to the emotional story of the mother, according to her pregnancy and relationship with her own mother. These fantasies then depend on the ability of the mother to now tolerate uncertainty about a being that lives within her and will remain there evolving for a while. If the external circumstances of a partner, emotionally and physically loving and present and, if a friendly environment towards motherhood helps the mother, she can share her fears and remain caring for the pregnancy. Both individual emotional attention and emotional group work clarify and contain, these natural anxieties, but intense and sometimes incomprehensible to parents. Many external circumstances, painful or pressing, can hinder or compromise pregnancy: problems in the relationship, significant losses during pregnancy, emotional abandonment. Experiences of this type can contribute to the discomfort and exacerbation of somatic and mental or emotional symptoms, they can even endanger the life of the baby.

I think that one of the most difficult moments for the mother occurs in the third trimester. These times can be precipitated into a situation with no way out, if the mother's mental state is not strong enough and contained by an environment that promotes her own container capacity to continue gestation. That is, emotional help to clarify and sustain her fears and uncertainty, and thus, face the basic anxiety of this trimester: the fear of her own death or that of her baby. This is the quarter in which, around seven months, the baby and the

mother begin to make decisions nearing the end of pregnancy. This appreciation, if we observe the entire pregnancy, and especially the birth, more as an experience shared between the mother and the baby, than as an irreparable trauma, raises us to consider the decisions as shared by mother and baby. Without 'adultizing' the participation of the baby, he makes too a decision, there seems to start the final stretch of this gestation experience. The 'internal version' occurs. The baby rotates in the womb, and begins his final position, looking for the channel through which he will be born. This perception, unconscious in the mother, raises, in my view, from an emotional vertex, a peak of anguish, perhaps the highest in the period of pregnancy. Or, perhaps comparable to the beginnings of pregnancy.

I suggest to start thinking about the mother of the premature baby, taking into account her mental state, starting from the moment in which the end of this experience begins to arise, this situation of anguish, somehow, the closest to the event of the prematurity. Already in the experience of childbirth, when it happens at term, we observe a mother in a special mental state. Fragmentation, depersonalization, emotional confusion. If we look at a mother before the terror of death and destruction, more dramatically, as presented in prematurity, we can understand which woman, which mother, we are holding and need to contain. Fragmentation advances towards more disintegrated states, the mental state is more primitive, and the mother is now also a 'premature baby', a premature mother lost in the space-time of a premature event. A Premature Meeting. The location of the baby in the birth canal, unconsciously perceived by the mother, configures a special mental state, which manifests itself in somatic or/and psychic symptoms and in dreams. For example, the mother contracts the pelvic muscles intensely and excessively, this could pose a pathological version, buttocks, lateral, etc. that is, there is an opposition to the 'version'. The corresponding fantasy, proposes Soifer [1] is that of terror of emptiness. The conscious feeling is that something that scares is happening, something pushes, or something is in revolution in the womb.

So now appear physical symptoms that imposed such as hypertension crisis, hyperemesis, diarrhea, constipation, sudden onset of edema, sudden and excessive weight gain, intense and frequent cramps. Emotionally, the mother begins to have anxiety crisis, death fantasies, her own or that of the baby, there is hypertrophy of sensitivity, permanent fears, sometimes unspecific, that something will happen. A period of depression can begin, the mother needs more than before, from someone's company. And, when the anguish is unsustainable, it can, as a more serious situation, occurs the early delivery.

Sometimes preterm birth has been imposed as the only way out, as the escape from unbearable states of uncertainty. This is what the mother supposes solves her intolerance, appeals to the evacuation mechanism to impose a premature delivery.

In dreams, the mother puts on her fears, her unconscious fantasies. When working emotionally with pregnant women from this perspective, clarifying dreams in group work, or individual work, greatly helps to alleviate their anxieties and thus the mother can continue her pregnancy, accompanied by the understanding of her emotions and the ability to think them, which decreases the tendency to act, in the body, this inability to solve your anxiety or anguish.

I am going to narrate a simple example, and staged in the dream, of fears of hasty childbirth, anxieties of death, and strange movements within her body, lived by a mother, in an easily understandable way for her. The pregnancy was followed by me from the beginning, in telephone consultations every time the mother considered emotional support necessary to think about her physical and emotional symptoms, also her dreams.

B is a 33-year-old woman with 7 years of personal psychoanalysis. It is her first baby. From around week 26, she began to present alarming physical symptoms: a sharp increase in weight, gestational diabetes, hypertension, uncontrollable irritability, overflowing anguish, "I feel I can no more," constantly repeated the mother. A dream was the alarm signal. She consulted me immediately by phone, because she lived in another city: I was with another young woman, we were looking for a clinic, we found it, and it was a very nice, old, and very preserved house. We entered there and when I was already inside, I realized that it was an abortion clinic, I woke up in a crisis of terrible anguish.

She writes instantly, in the diary she had been carrying since pregnancy began: “it was you, but I didn’t see you, you have been in my dreams for a long time, I don’t want you to be born before, remember that we have to wait, the time is almost here... Let’s not despair, so we can stay longer together, I love you, my baby”. I do not intend to make a dream analysis, just an allusion to the mental state that the mother understood, staged, and attended. They were posing, mom and baby, the imminence of separation. At the time of the anguish triggered by the unconscious perception of the internal version, the alarms, emotional and physical, were triggered. It was the beginning of the end. It was necessary to separate. And the experience was death, abortion. The internal situation of this mother and this baby is clear. The physical symptoms were controlled after analysing this and other dreams for several telephone sessions. Her baby was born at term.

A proposal about prematurity

In a previous work [2] on a baby kangaroo, 32 weeks gestation, I proposed to think, as I propose now, the occurrence of prematurity as a phenomenon of a level that is not, neither mental or psychic, nor somatic, but rather, a level of undifferentiation between these two instances. It would be a state, or protomental level [3]. That is, to say, a primitive mental life is presented in the individual that is exposed in bodily processes. In this state, in which there is no differentiation between the physical and the mental or psychological, observation, thought and judgment are not articulated, rather, these primitive parts of the personality “think with the body”, in obedience to laws of neurophysiology rather than psychology. In this protomental level in which mother and baby are, an increase in anguish, raises the failure of container-contain function, which, in essence, is the function that is configured, in its clearest definition, when pregnancy begins, and the mother, with her uterus, and her mind, is the one who harbours, or contains her baby; and the baby, in its slow organization, configures what must be contained or saved by that continent. Thus, mother-womb-mind, is the container, and baby-soma-emotion, is the container. For one to exist, the other must also exist. This is what makes the phenomenon a function: mother-baby, or, container-contained.

I will presume that the first data of separation between mother and baby are raised at the time of the ‘internal version’. A new idea capable of producing catastrophic change. In this state of turbulence, if uncertainty or the amount of anguish generated by this situation is not tolerated, the continent skin, the mother’s container capacity and the baby’s ability to remain the contained are broken. The function we were talking about is broken, fragmented, and its fragments begin to expand into a universe of uncertainty and despair.

I think that anguish can invade the mother in such a way that, as I said before, her container function is affected. Neither the mother, nor the baby, tolerate waiting more, an unsustainable state has been raised, it is vital for the baby to flee; the uterus has become threatening and unknown. It is also vital for the mother, to take out something that rebels internally, now her baby is perceived as threatening, does not support the uncertainty anymore. Let us think of this state as that, it is necessary to propose an emergency exit, a premature encounter between mother and baby is precipitated, with all these circumstantial data, internal and external. And I emphasize that, not only the baby is premature, the mother is also premature. It is so, in this experience so configured, when mom and baby separate, but approach at birth, this, I think, can be understood as a premature encounter.

It depends on the quality of prematurity the one who continues life, or one of the members of this dyad dies. We must not forget, however, that birth can be lived as an abortion, that is, “the baby is spoiled”, it is a baby more in death than in life. This quality of encounter demands a need for special attention and understanding. As workers of the health and as people in direct contact in the care of mother and baby, we have to explore and awaken, in ourselves, elements of tolerance, kindness and wisdom that make up a continent function available to this dyad and the family itself, to accompany moments of repair and emotional growth.

Once the premature baby is born, the mother is mired in a kind of sentence, has pleaded guilty to such prematurity. It is not worth repeating to herself intellectual reasons, or rationalizations about the causes of this ‘arrival ahead of time’, for her, inside her, something she did, or stopped doing, made the events precipitated in such a way. And the emotional state becomes even more confusing than the birth and naturally raises. How will her deal with that unknown baby, now threatened for her? Can she be close to him ‘without harming

him'? In premature mothers the fear of touching the baby is usually more intense, they, and the world, are more harmful, and often think, consciously or unconsciously, that they do not deserve to approach. I think they expect the baby's acceptance, that it is he who initiates the communication. We heard many phrases like: "As soon as I arrived, he looked at me, I think he recognized me". We could read this as if finally, the mother feels that the baby accepted her and forgave her failure. In very serious babies conditions, the situation is complicated, because the mother is more waiting for the signs of forgiveness, so she is able to approach and accept herself as a mother, as a successful giver of life and, in this way, prepare to be the protector and Caretaker of the life that now demands. Will she be able to fulfil the mandate, we would say, of the species? The baby's responses are food for the mother, food for strength and confidence.

When I talk about the mother-baby relationship, I mean the relationship that has arisen since pregnancy.

We must remember that this is not the baby she expected, this is another baby, not only is not the baby of her fantasy, is a baby that was not expected now, is a stranger, strange and distant. All this in fantasy, but part of this same fantasy is, to some extent, conscious in the mother. The undeniable presence of death is added to the state of confusion of birth, for both mom and baby. It moves in these mothers, the fear of death. Without naming her, the death is the closest companion right now. Even at the beginning of the kangaroo experience, they are mothers who carry their babies, with joy yes, but also with the terror of death, whom they perceive, shoulder to shoulder, struggling to take over of their babies.

Watching the mothers, standing, in front of the incubators is shocking, pulling their babies towards life, but the opposite force, death, is powerful and even more, with the advantage of not having any guilt, only the legitimacy of doing your thing. A mother standing in front of the incubator by touching her baby, with the back of her finger, without even daring to encompass it with her hand, to confidently take it inside herself. The approaches are fearful, insecure and with an amount of anguish that cannot be verbalized. Likewise, the baby's responses are magnified and interpreted by the mother, according to her willingness to be forgiven and now accepted by her baby. If this happens, the mother begins to grow in forgiveness of herself and self-esteem. At this time the Health Staff is vital to support the mother and encourage her in her attempts to approach to her baby; a single word, a single close instruction is for the mother approval, comfort and encouragement to encompass her baby in her mind, to accommodate their relationship within themselves -mother and baby- and for the purpose of fighting for life, and not surrender to death.

I have observed how, when these mothers arrive at the new-born unit, their first impression is to face a baby in the fields of death, despair flows immediately and they feel insufficient for him because they are also babies at the doors of the death. A clear explanation about the state of her child, and an emotional welcome, that is, performing a container-contained function towards the mother at this time, is to provide the model of containment she needs for her baby. Now this is the real baby, and this is the baby with whom she needs to establish that relationship in her mind, in her spirit; If the mother finds this quality of relationship in the health staff, when she is close to her child, she will be able to replicate this model with her baby.

On the other hand, if the father, the partner, now assumes this model of containment, the mother may further strengthen her continent action and be able to bond with her baby to exercise the container-contained function [4]. This one cannot be deployed if that connection is not established, that is, there will be no contained without container, nor will there be container without a contained, they may exist in isolation, for example, a baby-contained looking for a container, or a container waiting for a contained, but thus the function is not installed, it is not exercised. The connection is necessary, and the quality of it depends on some circumstances, from the somatic and psychic equipment with which the baby reaches the world, to the quality of human contact that they provide to the mother, the nurse, and all the health team. I still think that mothers in this experience should receive emotional support without delay. On this attention depends, to some extent, the disposition and quality of the bond that arises between mother and baby.

The mainland attention given, in the first instance by the father, then his immediate surroundings, and in a special way, the health personnel begin to repair her breast and mental space in the mother, to house that real baby, precisely, not perfect to her, as was the baby

of her fantasy. So now begin a whole effort to decode the nonverbal language of her real baby. When the mother can accompany her baby in the premature unit on a daily basis, almost permanently, the child's health improves surprisingly, and even more so, when the mother can carry her baby, skin to skin, her baby, in the unit of new-borns for several hours a day, every day, until completing their gestational period, or reaching the ideal weight, as is done in the Mother-Baby-Kangaroo experience. This opportunity is not only a physically super-developed opportunity for life, but an unmatched opportunity for mental health. The experience of being a Kangaroo Mother is essentially a restorative experience of life.

The Mother Baby Kangaroo methodology addresses this situation of mother and baby directly, immediately. The baby, who has overcome medical problems, carried skin to skin, to the mother's breast in the Premature Unit, as part of the Mother Kangaroo Program, in what is called early kangaroo, begins to respond with life and health; and the mother reconciles with her baby and herself as a being able to care for and keep her baby alive. The father who approaches this experience can never forget it; it can never be a banality for him to be a father. In the experience of the Kangaroo Program we have observed how the father gets closer to his premature son and his other children, if he has them. The family experiences a shocking change. It is the whole family that gets involved and engages in the task of helping the premature baby live. It is a Kangaroo Family.

The arrival of the Kangaroo program at a NICU (Neonatal Intensive Care Unit) immediately sensitizes staff: nurses, doctors, psychologists, assistants, therapists, etc. and changes do not wait. This will also be a Kangaroo team for mother, father and baby.

An experience in Colombia

In Bogotá, Colombia, several of the Kangaroo Program teams have sometimes implemented emotional attention according to the special moments faced by these parents-babies. They have psychologists who meet these needs. At this time, it was wanted to implant the group attention to parents-babies, as soon as they enter the program. Meetings are held with the methodology of the Operating Group [5] with the objective of receiving the anxieties of these parents, anxieties that they raise in the group, to be shared by all the participants, natural anxieties in this experience, but which are Hardly digestible. The group coordinator makes this digestion and returns elements easier to be understood by the parents, who recognize the relationship that arises between their internal feeling and the experience they are living; and how, by verbalizing it, they recognize the stories of all parents, and their own, for they are truly shared.

In emotional terms, they see themselves in the task of repairing a baby they have perceived as very fragile, and they, the mothers, or they the fathers, as very dangerous. Now they are protective shields of the menacing world and thus repair the damage that they themselves fear having caused their baby. They understand how all that fear, that guilt, are emotional states and natural feelings in the experience of motherhood, fatherhood and especially, being mothers or premature parents of premature babies.

When an especially anxious mother is detected, or very alone in the kangaroo experience, she becomes the centre of special individual attention, or as a couple, in order to receive her emotional state and help her digest her emotions, so that she can same understand their anxieties and can contain their states of fear, depression, loneliness etc. Single mothers, without a partner, because they are the most emotionally affected, the most vulnerable, require special help in emotional attention.

In this context of being a support matrix, an emotional strategy has been implemented for the care of professionals who attend the intensive care unit or premature care unit, and for the professionals that make up the Kangaroo Program team. We must not forget that they also need containment in the hard task of permanently receiving such strong emotions, they need to digest and restore tranquillity, solutions and humane treatment to their patients. This experience began many years ago in the Kangaroo House of Social Security¹, also

¹Kangaroo Casita is called the physical space and the service of the kangaroo program when it begins to be provided on an Outpatient basis. This modality is more implemented in Colombia, but not the joint housing whose infrastructure is appreciable in Brazil.

in the Santa Bibiana Clinic and in several other hospitals that implement the Program in the city of Bogotá, Colombia. It works with the teams of nurses, doctors and others, in ongoing training and in the analysis of their own emotions involved in the work. In this way, they return to their work detoxified from strong emotions that without thinking, may hinder their attention and service. These anxieties that recharge their emotional state were thrown into them as the only possibility of relief from the mothers, or the babies themselves, and not always the answer gives relief and containment, both to the mother and the baby. That is why, such emotions also need to be thought and thus digested by the professional.

For this work we also propose the methodology of the Operating Group to collect anxieties and give them an effective digestion. This work is carried out in a more spaced way and begins to be implemented now, at the same time, the Work Discussion methodology. In this experience, a case chosen by the participants is taken to the meeting, a case of their daily work that is discussed in order to understand the emotional states of minds of the patients, and also the emotional state of mind of the professional, beyond the manifest. In this way, their emotions are reviewed and understood. The professional gradually understands the patient and the emotional dynamics that are generated in their interrelationships.

The continuous review of material, relationships, bonding qualities, and so on, makes the professional truly sensitized and comprehends the relationships of his patient, and with his patient and of course his own relationships with other individuals. Thus, not only what is done is understood, and to whom we serve or provide the service. Here a permanent detoxification action of unthinkable emotions is offered, which have accumulated within the health staff, because the patient, given his inability to keep his emotions contained, has put them in the doctor, the nurse etc. If they do not have training and sensitive attention in this regard, they will also return undigested elements, and the doctor-patient or nurse-mother relationship will not work. It is important to understand that, in this case, the relationship of the baby or the patient in general with their disease will not change, nor will the mother-baby relationship prosper.

The work focused on this mother-baby dyad proposed by the Mother Baby Kangaroo Program has made us find aspects of the bond that had been forgotten by us, health workers, and in some cases, also forgotten by the parents themselves and that they demand the urgency of repairing the function of containing their babies. It is the rescue of Motherhood and Fatherhood. And in the health staff is the rescue of Emotional Relations between Human Beings.

Summary/Conclusion

In this little document we take a close look at the experience of being a Premature Mother. We observe the premature baby in this interaction, the family and the Health Personnel in the Newborn Unit, so important in this chain of events that they require a special disposition of continental, loving and welcoming mental states for the dyad and the family. In turn, these same qualities of relationship and attention are vital to the Health Team that operates in circumstances and events of such delicacy.

Note

Mother-Baby-Kangaroo Method

A premature baby is the one born before 37 weeks gestation. Between 28 and 31 weeks is considered an extremely premature baby. To address the shortage of incubators in the Newborn Unit of the Maternal and Child Clinic of Bogotá Colombia, in 1978, Dr. Edgar Rey Sanabria proposes mothers as living incubators. Thus, was born the Mother-Baby Kangaroo Method. The mother in the hospital keeps her baby skin to skin between her breasts, there the baby stays most of the time and is fed, as far as possible, to the mother's breast. Since 1994, the Outpatient Kangaroo Method was implemented. The baby goes home in a kangaroo position and is checked daily by the medical team.

The premature baby should remain in an upright ventral ulna on the chest, like a 'frog' attached to the mother's body, in direct contact, skin to skin. It is located between the two breasts with a cheek, alternately, against the mother's chest.

Bibliography

1. Soifer Raquel. "Pregnancy psychology, Childbirth and Puerperium". Ediciones Kargieman, Buenos Aires (1971).
2. Botero Hilda. "Observing a baby-kangaroo: the womb to gestate a mother-baby relationship". Presented in the IV International Colloquium on observation Esther Bick babies. Lisbon (1998).
3. Bion Wilfred R. Experiencias en Grupo Ediciones Hormé, Buenos Aires (1948-51 [1961]) (1966).
4. Bion Wilfred R. "Aprendiendo de la experiencia". Barcelona: Paidós (1962) (1980).
5. Pichón-Rivière E. "Operational Groups Technique, in the Group Process". From Psychoanalysis to Social Psychology. (1), New Vision Editions, Buenos Aires (1960) (2008).

Volume 10 Issue 8 August 2021

©All rights reserved by Hilda Botero C.