SECTION 3. MANAGEMENT OF CLINICAL PROBLEMS AND EMOTIONAL CARE

Early Emotional Care for Mothers and Infants

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ABSTRACT. The experiences of most child health professionals give them only partial insight into the complex emotional and behavioral changes brought on by maternity. This article describes an approach to clinical management and emotional care based on the principles of birth as an opportunity for reorganization and changes; the meeting of the mother’s “real” and “imagined” infants; appreciation of the infant’s strengths; and development of a therapeutic alliance with the mother. Central to this process is the creation of a safe holding environment for the mother, especially mothers of preterm infants. Pediatrics 1998;102:1278–1281; holding environment, Neonatal Behavior Assessment Scale, therapeutic alliance, premature birth, maternal representations.

ABBREVIATION. NBAS, Neonatal Behavioral Assessment Scale.

This paper describes a perspective on early clinical management and emotional care that evolved from my experience as pediatrician, child psychiatrist, infant developmentalist, and also as a parent.

In pediatrics, our concern most often is the integrity and functioning of the infant’s different organ systems. Our focus is on the infant as a unique living organism.

In child psychiatry, the infant is seen linked to his mother as a relational partner, where the mother’s representation of him is a determinant of his future. Here we see the infant as a repository of the parent’s attributions.

In child development, we try to demonstrate the infant’s competencies, preferences, adaptation to his immediate environment, and his stimulus thresholds. We seek to understand what the infant means, who he is as an individual. Here we see the infant as a person.

As parents, we experience the intense new emotions that emerge with the new life—facing the task of keeping the infant alive, meeting his needs, regulating the infant’s states, and establishing a new relationship, making him our infant. Here we see the infant as our own child.1

The experiences of each of the child health professionals do not prepare a parent, particularly a mother, for the revolution provoked by maternity. Each specialty has a partial view of the infant that can be far removed from the parent’s view and experience of their infant.5 This disparity has led me to an approach that integrates some of these four roles.

BASIC PRINCIPLES

This approach to clinical management and emotional care is based on several basic principles, described below.

Reorganization and Change

Moments of disequilibrium tend to open up a system for reorganization and change. Normal life crises, such as birth, provide such an opportunity. In addition, birth is an early time to conduct preventions or interventions that may be effective later on.

Imagined/Real Baby

At this crisis point, one of the mother’s tasks is to build a representation of her infant that integrates her expectation of the baby in her mind (the “imagined baby”) and the “real baby” in her arms. It is preventive and therapeutic to help through this process. This requires attention both to the infant’s objective behavior and to the parents’ interpretation and reaction to their infant’s behavior.

A Constructive View

The mother’s imagined baby may be seen as potentially problematic. However, it is far more important, but less appreciated, to consider her imagined baby as potentially constructive for the infant’s development.

Therapeutic Alliance

Fourth, when health care professionals have successfully provided a favorable environment for building positive experiences and representations, we enter a privileged psychological position in the parent’s mind. We are empowered to act as the professional person to coordinate the management of medical and emotional care. This is important because care most often is fragmented among several subspecialties and disciplines. In this sense, the process of facilitating the mother–infant encounter also creates very early and quickly a special therapeutic alliance that can be put to good use for ongoing emotional and physical development.
THE IMAGINED BABY

Knowing how the “imagined baby” develops in the mother’s mind is essential to understanding how a mother and caregiver can create a therapeutic alliance.

Long before she becomes pregnant, the mother has been building a representation of the child and family she will have. Depending on her style, personality, and life experience, these representations can be vague or precise.

The psychological process of preparation for an infant and a future family does not begin at the moment of conception. It has been in preparation since the mother’s childhood, as seen in doll games, or “mama and papa” games, and by the examples of maternal behavior seen in her family and surroundings, among friends, in books, on television, and in all of her life’s experiences.

During adolescence, genital maturation triggers a sense of her reproductive capacity—to have an infant that you bring into the world. This is part of the adolescent upheaval and leads to the definition of a new identity that includes that of a possible future mother. Marriage or living together makes imminent the possibility of having an infant. This leads to all of the choices relevant to that possibility, such as contraception or planned pregnancy. This developmental process thus begins in childhood and evolves through various phases into adulthood until it becomes intensely active during pregnancy.

While the physical pregnancy is going on in the uterus, the mother experiences simultaneously a mental pregnancy. This mental pregnancy consists of psychological changes that prepare the way for profound changes in her identity within her marriage, her family origin, her professional and social lives, and her sense of self. She works on her image of her infant, of herself as a future mother, of her husband as a future father, of her new nuclear family, of her infant’s role in this family as the next generation of her family, and of many other similar permutations.

This mental work is like a “personality genesis” that would be the counterpart of the infant’s organogenesis. These two simultaneous physical and psychological processes mutually influence one another during the entire pregnancy.

Mother’s Representation of the Infant

The richness, elaborateness, and specificity of the mother’s representation of her infant increases during the first months of pregnancy (Fig 1). Her sense of her infant makes a big leap around the fourth month, after the first ultrasonogram and feeling the fetal movements. It continues to grow progressively, reaching a high point at approximately the seventh month. After this summit, the mother’s representation of the infant loses some of its richness and specificity; the mother lets it fade and undo itself during the last weeks of pregnancy. It is as if the mother has to decrease her precise expectations of the infant to prepare for meeting her real infant.

The mother’s representation of her infant is not a coherent and complete image of a particular person-ality. It is the fruit of an exploration of the wishes and fears, past and present, that are woven together over time and integrated with real events that arose during the pregnancy. Conceptually, the mother navigates in her imagination between two groups of representations concerning her infant.

One concerns the wished-for baby: a boy or a girl, good looking, strong, athletic, charming or beautiful, vivacious, smart, easy tempered. Or an infant who achieves something she had dreamed for herself, one who has characteristics of her hero or heroine.

On the other hand, the same imagination is working on the feared baby: malformed, weak, trisomic, ugly, troublesome. One who will become violent, alcoholic, or criminal, just like some member of the family.

In the same way, she explores the idea of who she will be as a mother—thinking of her own mother and of mothers she admires and of others she despises. She does the same with the father, both of her families, and the different areas of her life that are touched by the arrival of her new infant.

All these representations constitute a vast repertoire of experiences in the mother’s mind. Some of them will naturally or forcefully emerge when she becomes a mother. But the nature of the perinatal period is such that the social environment can have a great influence by activating representations of the mother’s repertoire that then become reality.

The classic notion of “ghosts in the nursery,” as revealed during consultation in child psychiatry, has taught us the potentially pathologic function that representations of past relationships may have in the present. But there are not only bad ghosts in the nursery, there are good ones too (as well as good fairies). They play an important role as model for the mother for herself and as a positive inspiration for her future.

Near birth, if negative representations of the past are not expressed spontaneously, they should not be asked about. This is because the effect of asking could activate background representations that would not otherwise have come out. These then become vivid in the mother’s mind and influence her behavior with her infant, such as looking for a previous infant’s death in the family and dwelling on losses and separations.

Looking for the positive by emphasizing an in-
fant’s strengths provides a means to face the actual difficulties in the infant’s behavior. Looking for the mother’s representations of a “good mother,” those she has experienced as a support in her life and that give her confidence, may promote the most secure part of herself to enter her relationship with her infant.

Emphasizing the positive also contributes to a supportive emotional environment for the mother. She will feel cared for. This is essential to permit the building of a therapeutic alliance between the mother and care provider in the service of the family’s health.

**Birth: A Good Time for Intervention**

Birth is a moment of disequilibrium in the mother’s system. It is the moment when the imagined baby meets the real baby. And it is the moment when the mother’s representations and priorities change.

Survival of the infant emerges as the first preoccupation. When her infant is born, she first needs to make sure he is alive and to make him her own at a deep instinctive level—to physically experience the weight of his little body on her, his texture and scent, to feel him, warm and alive. After that, she wants to know that all is going well, that he is anatomically intact and in good health. The physical status of the infant answers this question.

When she has been reassured that her infant is alive and well, the mother seeks to meet this new member of the family as a person. She has put out all of her antennae to perceive who is this mysterious infant she has created and carried for so long. She is lying in wait for the slightest indication that might orient her. She will search to appropriate him through physical resemblances: “He has his father’s forehead and eyes, but he has my mouth!”, and through his behavioral similarities: “When he is hungry, you’ve got to be there right away! He is demanding like my father”; or “He sleeps a lot; in my family, we are all great sleepers,” and so forth.

The mother has created many different maternal and familial images during childhood and, more recently, while pregnant. These involve her infant as a person, herself as a mother, her early relationship with her infant and later with him as a child, and about her husband in his role as a father, to name a few. All of these images are in a suspension, like a cloudy emulsion in a liquid, ready to precipitate out of the mother’s system. It is the moment when the imagined baby meets the real baby. And it is the moment when the imagined infant she has created and carried for so long. She is lying in wait for the slightest indication that might orient her. She will search to appropriate him through physical resemblances: “He has his father’s forehead and eyes, but he has my mouth!”, and through his behavioral similarities: “When he is hungry, you’ve got to be there right away! He is demanding like my father”; or “He sleeps a lot; in my family, we are all great sleepers,” and so forth.

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Also during this phase, it is necessary to emphasize the very important role of the perinatal team. In the mother’s eyes, the maternity staff has an expertise such that whatever they say during these first days often will become indelibly engraved in her mind and can strongly influence her future relationship with her infant by reinforcing either a positive or negative preexisting representation. For example, a mother brought her 4-year-old child for a consultation because he was violent, kicking her, and she couldn’t make him obey her. Among her first words, she said: “Even in the maternity word, a nurse said that he was bad!” Of course, the nurse’s declaration didn’t make the infant bad, but her words resonated with her fear of having a bad infant. They left their imprint on her image of him and may have contributed to setting them on the path of the feared baby.

We can direct a mother on the path of the wished-for baby just as easily. It is crucial to realize that even if it is not as visible, in the neonatal period, words can have the same power as narcotic drugs.

**Premature Birth**

A premature birth occurring at approximately 30 to 32 weeks will not only produce a premature infant, but also a premature mother.

At approximately 7 months of pregnancy, the mother doesn’t yet want to see her real infant. In her imagination, she has a fairly well-defined image of her infant, usually that of a vigorous, active, and gratifying 3-month-old—not a full-term neonate. Unfortunately, with an early birth, she finds herself facing neither a gratifying 3-month-old nor even a solid and well-developed full-term infant. Instead, she encounters an infant who is frail, not very pretty, fragile, hyperdependent, and easily overwhelmed—an infant for whom she is in no way prepared. She is a premature and disappointed mother.

Even more, this unfinished and vulnerable infant makes her feel like a mother who has not been able to fulfill her pregnancy and become a real mother. This feeling of incompetence is confirmed by the fact that specialists and sophisticated equipment are needed to care for her infant, and worse—that she can do nothing for him. This feeling of uselessness is reinforced by the physical separation from her infant, who is placed in a neonatal intensive care unit.

She is a mother who is premature, disappointed, and isolated. She experiences herself as vulnerable and having failed. From a psychological point of view, the mother of a premature infant is like a fragile piece of china.

Above all, health care professionals should avoid stigmatizing her as a psychiatric case. At the same time, we can help her a great deal by recognizing her vulnerability and helping her to connect with her infant.

**TECHNIQUES FOR EMOTIONAL CARE AND CLINICAL SUPPORT**

Two basic principles form the intervention for full-term newborn and premature infants. First, we must provide the mother with a safe holding environment from an experienced, accepting, and warm person. For a premature mother, this holding environment must respect the timing of a woman who has been thrown into the role of mother, but is not ready to take it on. This holding environment must gently accompany the mother through her accelerated metamorphosis.
Second, we must recognize that during the perinatal period, the mother is psychologically open to the negative as well as to the positive. We need to make it a constructive crisis by validating her in her new role and by avoiding all criticism and disqualification.

Therapeutic Alliance

It is important to develop initially a therapeutic alliance with the mother. I do this by explaining how I can help and then asking how she feels. I try to develop it along the lines of a semistructured interview, looking for the content and quality of the experience she has had.

The interview touches on the delivery—How did it go? Is she pleased with herself? What did she feel when she saw her infant? Was she surprised? What did the infant look like? What did he do?

It touches on the pregnancy—Did anything particular happen? What did the infant feel like? How did he manifest himself? How did she imagine him/her?

Then I ask more general questions such as: Are there other babies in the family? Does she have experience with taking care of babies? How does she feel about her new role as a mother? Confident or worried? Will her husband be at home for the first days? Does she have a support system that will be available for help?

Finally, I want to know how she sees her infant now: How does he look physically? How does he behave? What does he do when feeding, sleeping, or bathing? When is he alert? Is he cuddly? When he cries, is he easy or difficult to console?

In summary, I look for the quality of the experience that she has had, for her sense of having had the infant she expected, her self-confidence in her new role as a mother, her support network. I look for the elements that will help her feel satisfied and confident.

After, never before, a sense of mutual trust has been established, and after I have a sense of the mother’s expectations of herself and her infant, I start to do the Brazelton Neonatal Behavioral Assessment Scale (NBAS) with her at my side. I try to do the complete Brazelton NBAS and make comments along the way. Depending on the infant’s state and the mother’s needs, I will interrupt the procedure to address her concerns or to give her the infant to comfort or touch.

When the scale is completed, I usually place the infant into the mother’s arms and start to comment on the examination. I try to answer the concerns she may have evoked earlier on. I comment on the infant’s behaviors that confirm her representations or observations (the positive matches). I address the areas where the infant’s behavior may present difficulties and help devise strategies to manage them. When there are negatively distorted perceptions, I try to use the infant’s behavior to correct them.

In the case of preterm infants, I use the Newborn Individualized Developmental Care and Assessment Program that Heidi Als has developed as my theoretical reference and practical guide to comment on the infant’s behavior periodically during hospitalization. These comments about the preterm infant are used in the same spirit as those about a full-term infant’s behavior during the Brazelton NBAS.

SUMMARY

To facilitate the integration of emotional care and clinical support, I first establish a holding environment and a positive therapeutic alliance. From that privileged position, I attempt to align the mother’s vision of the infant with respect to who he really is and to who she really is. This process promotes their attachment and bonding during a very sensitive moment in their lives.

In this approach, the central focus is not on the infant’s behavior during the NBAS (the real baby) nor on the mother’s representation of her infant (the imagined baby). Rather, the focus is on the specific match between the real and imagined babies. It is this slight but important difference that distinguishes this technique from the original developmental pediatric approach in which the NBAS was used for nonspecific education about the infant’s capacities. It also differs from the traditional psychodynamically oriented parent–infant psychotherapy approach, in which the mother’s representations and their history (the origins of the imagined baby) are the central focus.

This emotional and clinical support adds a new dimension to clinical care. This caring person is someone who acts like a doula during the immediate postnatal period, but a doula who tries to bring about the birth of the infant in the mother’s mind and who promotes the birth of the psychological mother.

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