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Reflections on the Notion of Traumatism at Birth

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Abstract: This is a paper reflecting upon the notion of traumatism at birth. We argue that what can be traumatic is not birth itself but the traumatic conditions in which birth takes place and its relationship with the history of the subject and family. We defend that it is essential that professionals working with preterms and their families pursue their effort in limiting traumas through an increasingly enlightened assistance, for example, by requesting the parents to talk to their babies, to tell them their first and last names, and about their families. The objective of this procedure being for the parents to reconstitute with words the language environment in which these babies are seeping.

Resumo: *Reflexões Sobre a Noção de Trauma ao Nascer.* Este artigo reflete sobre a noção de trauma do nascimento. Nós defendemos que o que é traumático nao é o nascimento mas as condiçoes deste nascimento e a relação destas com a história do sujeito e de sua família. Neste artigo mostramos como é essencial que os profissionais trabalhando com pretermos e suas famílias continuem seus esforços a fim de que os traumas, possam ser diminuidos através de uma assistência cada vez mais esclarecida; exemplos sao dados de como recomendar aos pais para conversar com seus bebês, dizendo o seu primeiro e último nomes e contando a história sobre sua família. O objetivo de tal procedimento é reconstituir com palavras o ambiente de linguagem que esses bebês estao vivendo.

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Introduction – Traumatism at Birth

It seems to me that the notion of traumatism at birth is not to be taken litteraly. In principal, being born is not a traumatic experience, it is a stage in human life. On the contrary, what can be traumatic are the conditions in which birth takes place and the way it can echo in the history of the subject , of his family. The birth of a premature baby can be traumatic but it will be felt as traumatic only according to the place it will occupy for both parties, which will determine its intensity, especially for the mother. In that sense, the effort supplied by the medical teams

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which support the child is tremendously important for the short and long-term prognostic.

During a conference in which I took part in Brazil, I had the opportunity to see the projection of a Japanese video which showed the experimentation of artificial plasma. One could see a ewe on which a caesarian is performed; the umbilical circulation of the foetus is plugged into the artificial placenta; then, the baby is extracted and is placed immediately in a sort of tub, full of a transparent liquid, in which he goes back into a foetal position on the spot and seems once more serene.

What is most impressive, is the violence that one feels at the moment of separation in comparison to the appeasement that the animal seems to express when it finds its antenatal sensations once again. One immediately thinks of what a highly premature baby strives for : to rediscover those antenatal sensations which have been memorized, because they are for him/her who is separated from everything s/he knows, the only identitary references that can bring him/her a feeling of security and continuity.

The Mothers

After separation at birth, they seem to be moved, even have feelings of rejection, fear and avoidance. Others fight to see and look after their child, bored into by the strength triggered by the baby, which Winnicott (1975) named primary maternal preoccupation. It is a kind of obsessional mania which mothers suffer from after childbirth.

Usually, this "mania" comes most often with the occurrence of baby blues, a transitory depressive state which appears with most parturients around Day-3. With mothers of premature babies, one does not witness baby blues; it is postponed, replaced by a feeling of sadness brought about by the situation. However, it will occur within the three days following the recovery of their child. It is one of the arguments which enables us to assert that baby blues is triggered by the presence of the child and the place he comes to occupy in the maternal unconscious in the aftermath of the meeting. In this context, how can we help these mothers?

In a hospital maternity, it is posssible to restore their narcissism by encouraging them to visit the child as soon as possible, while explaining to them that the baby is waiting for that visit because at that time s/he should still be under his/her mother's umbilical perfusion 24 hours a day! One must specify that s/he recognizes them, that no one can replace them by their side. One must also explain to them how to decode the expressions of their newly-born, how to delicately touch him/her, explain the fact that his/her faculties of concentration are very weak but that, even when asleep, s/he perceives the presence of the mother if she is in the room.

A picture of the baby at birth will be handed to the mother and it will be suggested that a piece of fabric soaked with the smell of her body be left in the incubator. This will reassure the baby when the mother is away. Lastly, one can advise to tell the child his/her first and last names, those of possible sibblings who are waiting for him/her, the reason of the separation, of care and what is hoped for him/her. Tell the baby that s/he has not been abandonned but that s/he is trusted over to a medical team until s/he is fit to go home. Thus acquainted with their maternal functions, most mothers begin to see the light.

Those mothers are held by a nameless traumatism, that can sometimes be seen in the difficulty to name the baby at the beginning, leaving on the incubator an inhuman number. They are suspended by a feeling of unreality and the first visit to the baby can be very disappointing if the mother has not been prepared or supported. The famous imaginary baby is confronted to a reality which is difficult to articulate. This fantasy to which they hang on can come and cancel the birth and provoke a feeling of unreality. They will have to become acquainted with a baby which is not very gratifying, learn to decode his/her expressions, form a relation with him/her. The risk might be the objectifying of the baby, somethinng one often comes across in certain services.

In this context, the team is sometimes put to the test, since some mothers deem themselves to be the only competent ones and can go so far as to suspend the visits. Others will trigger the agressivity of the team by judging it to be ill treating. This attitude should be interpreted as a desperate attempt on the part of certain women to recognize themselves as good mothers, thereby pointing to the bad mother, that person who does not respect and hurts her baby. During this separation, the support of the team must enable the mother to cope with important psychic alterations which will allow her to build, with the help of their baby, a maternal instinct which is sometimes lacking.

Certain paediatricians have tried to limit the devastating effects of separation when it is perceived as a parting, as a heartbreak by the mother and the father, and by the baby. They have thought up "mother-kangaroo" units to counteract this perception. The idea is to move the team to the baby and the mother to avoid separating them. It applies to light prematurity. The mother remains hospitalized with the baby until s/he is discharged. Thus, the baby gets to safely meet his/her family, the parents are associated as much as possible in the care. Birth remains a family event and the baby can grow amidst words from his circle of relatives, naturally introducing him/her to the society of humans. Sometimes a separation, even a very short one, cannot be avoided. It is then frequent to note that if the baby is given back to his/her mother within a "kangaroo unit", it is sometimes difficult to get things going again! They do not necessarily recognize each other right away and a lot of work is to be undertaken to assist them.

Those women who become mothers prematurely have not experienced the psychological stages of the end of a pregnancy which would have enabled them to be ready to cope with primary maternal preoccupation concerning a baby which is in need and in demand. In a service of neonatology, not only are those stages skippped, but furthermore mothers do not have their baby with them. It is then up to the team to take over, save the babies and enable the women to become mothers.

Medical words play a considerable part; they give an often vague prognostic, which will nonetheless allow the parents to remain hopeful, to maintain the strength of life which was at work during the pregnancy. They will enable them to remain focused on the future, without losing too much faith in hard times, in order to maintain a symbolic pregnancy of the child through their will. Sometimes, that will not be feasible. Then, the team, without being judgemental, will have to take care and take charge of the baby at times when the parents cannot manage any

longer. They will have to leave the place vacant and occupy it once more as soon as they can.

At the end of the day, some mothers will feel trouble in recovering their baby, if not resorting to the technique. The team will have to broach this situation as a weaning phase, time and assistance need to be provided; one should listen in order to cope with the arrival of baby blues.

The Babies

When foetal life is interrupted, the baby, which should still be a fotus, finds himself ill-adapted to aerial life. Naturally s/he will require an adapted assistance and the services are increasingly engaged in that field. But s/he will also need a relational life in order to inhabit his/her body in the eyes of others, like a subject acting in his/her own life, communicating with others s/he needs to survive.

Amongst psychotic adults met in psychiatric hospitals, a certain number were former premature babies for which sensorial and relational isolation which they had to bear in incubators had triggered an experimental psychosis. Respect for the psychic needs of the baby, as well to his specific sensoriality, is thus essential.

Indeed, a premature baby sees and recognizes his mother within 48 hours; s/he senses and recognizes the smell of his/her mother, of her milk; s/he can taste, which raises the issue of breastfeeding in neonatology where it is often impossible, whereas it is known that the composition of breast milk is adapted to prematurity. The preterm baby hears and recognizes voices and has preferences; s/he processes language and memorizes it and furthermore the prematur baby is sensitive to intentions and affects conveyed by language. Haptotherapists assert that foetuses are "happy look-outs"; premature babies are certainly not as happy but observe all the more.

Touch is the sense which appears the first in the life of the foetus. S/he is sensitive to painful stimuli as early as the 17^{th} week. Analgesia is currently used in foetuses in case of an intervention on him, the same procedure should be used with premature babies. A premature baby can be "attacked" by touch if it is not performed softly, tenderly and expertly; it should be adapted to his/her availability and his/her heightened sensitivity. When touch is appropriate one finds Immunoglobulin A (IgA) in the saliva of highly premature babies, who have been ventilated and artificially fed. Treated with the respect owed to their sensitivity, they cope. One has also noted the reduction of the time babies in "kangaroo units" spent in hospital.

When sleeping, the baby multiplies his neuronal connections. In a neonatology service, his/her cycles are ceaselessly upset, s/he is often disconnected with the day-night rhythm he had in his/her mother's belly, as the light is almost always on and too intense. What price does s/he pay for his/her treatment?

The need for an adapted holding, but also for the aknowledgement that a baby cannot live without the other, be it the mother, the father or the members of the team, will enable him to grow in a physical and psychic environment. He will become part of numerous human networks through which s/he will live more or less successfully according to the stengths of life s/he will draw in them, and to his/her

personality. The success of communication between himself and the others might enable him to function as a subject and not as an object on the verge of collapse.

Today, it is admitted, even overstated, that babies should be spoken to. In the case of highly premature babies, one can wonder who should do the talking, what to talk about, when and how to do it. What holds power over the baby is genuine speach, that which is said at the right time by the right person and which is coherent with his history. As the hospitalization of the child does not hold the same meaning and will not be experienced in the same way by each family, what is his/her changes. Parents if they are able to, should talk to him, or else a family member can do it, tell him his first and last names, about his family. The idea is to deliberately reconstitute with words the language environment in which s/he is seeping. S/he must be told the reason for the care s/he is under, tell him about the pregnancy too, what preceded it, in a nutshell, tell them/their history.

Babies hang on to words, looks, draw in them the energy they need. They must be given enough time to respond without overwhelming them with a flood of words, like a tape recorder. One should give a meaning to those words, embody them and transmit them to the child along the line of what Trewarten (1979) called protoconversation, ie allow him/her to take part in conversation while taking into account his/her reactions.

This attitude becomes crucial when the baby is abandonned, in the case of a birth when the baby is given up for instance. Those babies, which are disconnected with everything they know, with everything they have memorized, and this for good, will only be able to give their lives a meaning through a spoken link, the only one which can bring them reassurance and identity. For these babies, strict protocols of responsibility should be enforced because the children of people can become the children of every one, even anyone, because of their temporary status as a weightless gravitating being in the fantastical field constituted by the parental projections of each. It is too tempting to take on the role of the parent of the nameless child! The blunders of teams occur frequently; those are situations that should be handled very cautiously with the public and private tutelary organisations and with the psychologists.

The Fathers

At birth, the mother introduces the father to the child. In the case of great prematurity, it is seldom possible and it is in fact the father who presents the child to the mother when first visiting. The latter often feels that her labour has been robbed from her. Sometimes a first meeting between the mother and the baby occurs at birth, but it is short, furtive and always frustrating.

The father who follows the child in the intensive care unit will become the link. He will thus be placed, sometimes against his will, in a motherly position. Sometimes, he is the only one to maintain the link with the child, since the mother, because of her history, has excluded herself under the pretence of guilt which has taken the shape of rejection. The father will not feel at ease for all that. Ideally, the father should support the mother so that she in turn can support the child.

Fathers should not be made to change nappies and bottlefeed. A good father is not necessarily one who mimicks the mother, but one who helps the mother to

find the right place by the child. It is sometimes difficult when the separation rings like an echo in the history of one or the other, hindering the child from filling his/her seat. The help of a psychologist will then be required. This raises the issue of knowing whether the psychologist in the service should systematically see all parents. Apart from practical difficulties, some parents do not wish it. It is then up to the psychologist to work with the team as a speach mediator.

Conclusion

In conclusion, we highlight the fact that greatly premature babies are sometimes labelled "premature" for their whole life. This concerns above all those which have shown fragility through medical complications. Those for which everything went well do not seem prone to it. One further reason for professionals to pursue their effort in limiting traumas through an increasingly enlightened assistance.

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