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Guidelines for contributors

AAIMHI aims to publish three editions in March, July and November. Contributions to the newsletter are invited on any matter of interest to the members of AAIMHI.

Referenced works should follow the guidelines provided by the APA Publication Manual 4th Edition.

All submissions are sub-edited to newsletter standards.

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Opinions expressed in this newsletter are not necessarily those held by AAIMHI.

The Ann Morgan Prize, 2010

In 2009, after several decades of active service to the AAIMH (Vic), Dr Ann Morgan retired from her official role as Vice Chair of the committee. An annual prize for clinical writing seemed to be a fitting way to honour her, for who she is and for what she has given to the field of Infant Mental Health in Australia.

Ann has touched the lives of infants, parents and colleagues who have been fortunate enough to meet her face to face. Through her teaching, mentoring, supervising and contribution to countless clinical discussions over the years, Ann's understanding, her wisdom and her knowledge has travelled widely and enriched the clinical work of infant mental health clinicians practicing in many places around the world. The Ann Morgan prize was created on their behalf and on behalf of the infants and families they work with, as our way to say thank you, Ann.

The Victorian branch's vision for the prize is that it will bring together two of Ann's many passions. The first is the infant and her experience. Ann always speaks with a clear strong voice, asking that the infant and her experience not be overlooked in the clamour of increasing political, organisational and financial demands for research and policy. Important though they are, Ann asks us not to forget the infant before the clinician – here, now, distressed and in need of help and understanding. The other passion is literature. Ann delights in good writing.

The essay prize was created to invite contributions that would illuminate something about the infant's experience and also be a forum for creative writing not bound by the rules and restrictions defining many professional publications. The word 'essay' may have its own limitations, and we will drop that from our description in future years. Our hope is that the prize will continue to gather interest and that next year it will attract an even stronger field.

Julie Stone was the administrator of the prize. Her role was to receive the entries, to read them and to ensure they did not contain any identifying information. There were entries from Victorian members, and AAIMH members working in other states of Australia and abroad. With a cover sheet that said simply Essay 1, 2, 3 etc. Julie sent them off to three judges. All the essays were read by Ann Morgan, Campbell Paul and Joanna Murray-Smith. Joanna is a Melbourne-based award-winning playwright.

The administrator and the judges then met together for a lively and vigorous debate. It was a diverse field and every contribution had its merits. The judges thoughtfully considered each entry. Finding it impossible to come to a clear winner, they agreed the prize should be shared by two of the entries. Fiona McGlade and Sophia Xeros-Constantinides are joint winners for the inaugural Ann Morgan Prize.

Fiona McGlade is a psychiatrist in private practice and living in inner city Mel-

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bourne. For the past ten years, her work has been predominantly committed to the care of parents and infants. In counterbalance to this work, she enjoys music and literature and makes regular escapes into the Australian landscape.

Dr Sophia Xeros-Constantinides is a medical practitioner with over twenty years' experience in mental health working with women, children, families and with mothers and babies. For the last fifteen years she has been with Eastern Health Child, Youth & Family Mental Health Service (CYFMHS), previously known as CAMHS. As coordinator of the Infant Mental Health Group Therapy Program over the last eleven years, she has been involved in providing clinical service for distressed mothers and babies. She is co-author, with Smith and Cummings, of *A Decade of Parent and Infant Relationship Support Group Therapy Programs*, which was published in the International Journal of Group Psychotherapy, 60 (1) 2010, pp. 59-89. For many years Sophia worked at the Mercy Hospital for Women in the Mother-Baby Outpatients, and at the O'Connell Early Parenting Centre, assessing the mental health needs of women in the perinatal period, and offering psychotherapeutic support. She has a private practice in psychological medicine in the Fairfield area. In addition to these professional involvements, Sophia is a post-graduate student in Fine Art, and has a developing interest in the visual representation of the mother-baby relationship in Western culture.

A baby in the neonatal intensive care unit

Fiona McGlade

Introduction

Our society's ongoing developments in technology and its introduction into medical care have promoted growth in the rapidly evolving field of Neonatology and the concomitant establishment of the Neonatal Intensive Care Unit. These units are interdependent with main hospital bodies but also operate in relative autonomy with their own dedicated staff, culture and daily rhythms. Families are drawn into these cloistered worlds in the wake of medical emergencies involving their infants which have activated our society's most acute medical response. These stays may come to represent anywhere on the spectrum between a brief transitory interlude or to be the only environment that an infant comes to know. The infants' families are frequently required to advocate for their infants during crucial management decisions whilst themselves grasping for information, understanding and guidance about events known and unknown in circumstances beyond their control. It is to assist these families in their desperately onerous and invidious task, that I would now seek to explore further the circumstances of one such baby and her family.

I will call the baby Charlotte although this is not her real name. She is a female baby, approximately four months of age and dressed in a freshly laundered white body suit with yellow trim and matching bunny booties. Her skin is pink and flawless, her eyes are brown and clear and gaze trustingly outwards. She lies seemingly at ease, open to the surrounding world, with her head resting heavily upon the pillow and her legs splayed slightly apart. This baby's appearance displays the hallmarks of a baby who is meticulously cared for and deeply loved.

This baby lies on a clean mattress which rests on some blue hospital sheeting. Her right arm lies relaxed by her side but her left arm is extended towards her head supporting a hospital splint bound to her forearm which safeguards the placement of intravenous lines. A thick band of flesh-toned adhesive tape stretches across the baby's cheeks and around her face, anchoring and securing into place two tubes which extend into her nostrils. The thinner tube enters her left nostril and travels down into her stomach, carrying nasogastric feeds of the breast milk which her mother regularly expresses for her throughout the day. The right tube is a thicker tube, itself being further bound with tape to help avoid irritation of the baby's delicate epithelial surfaces but causing some stretching of the nostril to permit its entry into the nasal cavity. This tube is connected externally to a more complex apparatus of plastic chambers and tubing and electrical cords which all extend from a ventilator machine positioned beside her crib. The tube penetrates and disappears into her right nostril, presumably to extend down through the back of her throat to reach towards her upper tracheal region.

The baby has required the imposition of ventilatory support since the first moments of her life when, after a precipitate but otherwise uncomplicated vaginal delivery her newborn body failed to achieve the fundamental function of taking her first breath. Her delivery room became the scene of a neonatal emergency resulting in her transfer for neonatal intensive care. The equipment described have been essential accoutrements, providing vital function support and from within which she has grown, developed both physically and emotionally and formed an intensely loving attachment between herself and her parents. However, this baby's health remains significantly compromised and her parents are now grappling with the meaning and implications of this realisation for their baby's ongo-

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A baby in the neonatal intensive care unit (cont.)

ing circumstances.

The NICU environment

Baby Charlotte was initially admitted to an NICU (neonatal intensive care unit) attached to a major obstetric teaching hospital in a capital city. Like all high dependency units, it operates in an adjusted time zone whereby there is some reference to the normal diurnal patterns of the outside world whilst maintaining a capacity to rouse itself into high activity at any time around the clock. It prides itself for (amongst other things) its philosophy of 'family-centred care'. Parents are permitted 24-hour access to the ward and are encouraged to be major participants in their baby's care. In collaboration with the clinical team, they are encouraged to draw up a care plan which incorporates aspects of their observations and opinions regarding their infant's communications and care preferences. The Unit operates with an atmosphere of quiet and respectful efficiency.

The babies lie in their humidicribs on a selection of mattresses and coverings positioned to form a supportive 'nest'. Surrounding the humidicrib is a heavy array of medical equipment necessary for the monitoring and support of the infant though, in most cases, it appears possible for the families to interpose themselves between their infant and the machines to provide a sense of a supportive family circle. There are comfortable chairs provided but, notably, no facilities present to sleep beside the baby overnight. Balloons, photographs, teddy bears and bunny rugs are among the range of personalised items that provide the backdrop for each family's individual space

The staff members have been alerted to the imminent transfer of a premature newborn baby from the delivery suite. This has prompted a purposeful buzz of activity as an area is cleared, machines are gathered and checked whilst instruments are cracked from their sterile containers to be laid available onto trolleys to be at hand when required. The baby arrives in a humidicrib surrounded by a retinue of staff, which includes nurses, a paediatrician and a research team. There are no fewer than ten clinical staff, mostly dressed in blue hospital gowns, involved in the transfer process when the baby and his medical history are handed over to the receiving NICU team. His father hovers anxiously at the door. He has accompanied his baby on this emergency journey following his delivery but now appears uncertain as to where he should be. He seeks assurances from the staff that it is all right for him to return to his wife who is recovering from a caesarean section. The father and several staff members retreat, leaving the NICU staff to get on with the tasks of stabilising and settling in the baby.

The baby lies in his crib under a piece of bubble wrap for warmth and protection, further surrounded by an imposing edifice of medical equipment. His tiny body is supported down within the concavity of the mattress such that the bubble wrap over him rests almost flat. His presence is indicated by the rapid fluttering of the bubble wrap in response to his chest movements as gases are pumped in and out of his lungs. The clinicians have procedures to perform which include inserting a nasogastric tube, establishing venous access through an umbilical vein and the placement of temperature and cardiac monitors on his skin. The clinicians maintain strong focus to achieve their tasks with the minimum of stress upon the baby. The baby is then positioned for comfort, placed under warm coverings and closely monitored by the staff until his parents and family become available for involvement in his care.

Delivery and arrival into the NICU

It is within this environment of advanced medical care and technology that Charlotte and her parents were first united after her birth. The parents were swept along by the events of the early and precipitate labour, to be then confronted with the nightmare of their baby failing to breathe at birth and requiring resuscitation and immediate transfer to the NICU. Whilst their baby remained located within the same hospital, she had been removed from them and they had been denied the opportunity to share her first moments or to offer their protection and care as she first encountered the world.

From her first day of life, Charlotte is a patient. She receives twenty-four hour nursing care and her body's vital functions are supported by the medical equipment, most critically the ventilator, positioned beside her crib.

The parents visit Charlotte shortly after her admission to the NICU. She is their first baby, they are both in their thirties and their lead up to becoming parents has presented them with some challenges. Like most couples, they had juggled between themselves the ambivalent feelings of fear, excitement and hope as the pregnancy advanced. The mother, I will call her Margrette, has struggled with doubts and anxieties about her suitability for motherhood and the changes that it would bring to her life. She had found herself to be somewhat isolated with her apprehensions, leading her to seek psychological support prior to the baby's birth. For George (not his real name), his new baby and the role of fatherhood have been long, and perhaps impatiently awaited events. It is unlikely that either parent could have ever anticipated or prepared for the disorienting and emotionally overwhelming circumstances that they found themselves facing when they first came together with their baby as a family.

The parents first view Charlotte through an obscuring landscape of hospital technology and staff. She appears somewhat remote and alien as she lies bound to her crib by a network of tubing. Despite these obstacles and her own previous reticence, Margrette is

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A baby in the neonatal intensive care unit (cont.)

aware of visceral stirrings of connection and protectiveness towards her newborn. She fears that her own maternal strivings could compromise the medical care delivery so she refrains from reaching out to her baby. As the days go by, Charlotte's health issues remain critical, necessitating an ongoing series of tests, diagnostic procedures and further clinical opinions. The nursing attention to ensure the functioning of equipment and systems towards the meeting of her needs surrounds her with a continuous revolving routine.

Margrette is impressed with the professionalism of the staff but is also somewhat intimidated by their medical expertise, which she believes trumps any contributions of her own. She feels that there is little she can do for Charlotte and fears being regarded as a nuisance by the staff. She continues to attend the ward for much of each day and provides freshly pumped breast milk for her baby. It is some days before the parents are permitted to hold baby Charlotte.

Awakenings

Central to this concentrated focus of medical effort and parental preoccupation lies the infant. For some time, the medical acuity regarding her physical condition maintains an eclipsing dominance over her broader development, attachment needs and subjective experience. It is to be borne in mind that this baby's struggle is at the must fundamental level of maintaining vital respiratory function. This imposes an ongoing clinical urgency upon her physical viability and a precarious conditionality upon her day to day, or perhaps minute to minute sense of being. The subjective nature of these circumstances would likely extend beyond the limits of normal empathic or imaginative understanding.

Charlotte's clinical management has required that she be transferred to another NICU, this time attached to a paediatric hospital. She continues to be cared for with a high standard of skill and professionalism, though perhaps with a slight increase of emphasis upon her medical 'caseness'.

The parents attend every day but they are unable to be present for their baby during the night or when she is removed from the NICU to undergo clinical procedures and operations. Charlotte regularly receives sedation to help settle her distress, particularly in the evenings and at times when her airways are blocked and require suctioning. Despite this, the parents observe their baby to have periods of settledness, whereby she seems calm and free of her previous distress. There is a sense of oscillation between discrete emotional states with harmony restored when a physical distress is relieved.

A number of factors would have undoubtedly impacted upon the development of Charlotte's emergent consciousness and bodily awareness. Her sleep/wake cycles of infancy have been manipulated by sedative medications. She has been anaesthetised for procedures from which she would wake to her body sending her unfamiliar and possibly painful sensory signals. Also she has experienced some separation from the stabilising and containing influence of her parents at such times of high stress. This scenario suggests a likely disruption to the dynamic processes of consciousness development and sense of continuity of experience. As opposed to the trend towards a drawing together of the fragmentary elements of early experience towards some cohesive matrix, Charlotte's nebulous infant awareness may have undergone further fracturing and splicing towards an otherwise more disjointed entity.

Attachment and relating

Despite the many obstacles and handicaps presented, this family do come to find and recognise one another for who they are and to form deep attachment bonds. Margette acknowledges a steady transformation within herself from a primal protectiveness towards her baby into an intense and reciprocated loving relationship. As Charlotte has grown, the parents have enjoyed handling and caring for her. They are keen to provide comfort to soothe her when she is distressed. Charlotte loves to be held by her parents. She will gaze intently and searchingly upon her parents' faces and into Margrette's eyes. At these times, her mother finds it near impossible to look away. She holds her baby, encircling her within a protective intimacy that she knows to be love. But she suffers as she contemplates the enduring struggle of her baby though simultaneously sharing a moment of bliss.

Inevitably, Charlotte's parents come to regard her as having her own personality. They describe her as 'sweet', 'a gentle soul', 'uncomplaining'. They recognise her preference for being clean and dry and, of course, for being cuddled. But there is also a sense that Charlotte is serious and possibly perturbed. Her expression appears at times to reflect some inner gravity. It agonises them to consider that Charlotte's growing awareness of herself and her world may be filling her with fears and distress.

There are also questions as to how far Charlotte's perceived personality traits are forged by the pressures of her current circumstances? Perhaps her uncomplaining nature is representative of an enforced passivity in response to her severe limitations of opportunity?

There is an occasion when Margrette gives Charlotte a bath. Charlotte enjoys the sensations of the water and the more expansive sense of her body. She stretches out her legs whilst supported by the water and her mother's hands. Her feet reach the end of the bath and as she pushes up against it, her body suddenly propels backwards from her efforts. Margrette observes Charlotte's response of wondrous as-

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A baby in the neonatal intensive care unit (cont.)

tonishment as the baby realises that she has caused 'something to happen.' This moment of pride and achievement is achingly underscored for Margrette by the contrasting realisation of the range of developmental satisfactions to inevitably preclude her baby.

Manipulations of hope

Initially, there was a resolute optimism amongst most concerned as regards to Charlotte's prospects and therapeutic outlook. The parents consented their baby to a mounting series of interventions with the belief that eventual recovery lay in the following of all treatment options made available. Through time and the dispiriting impact of clinical disappointments, this belief has eroded and distorted into a different quality. For George, his days are motivated by a dogged determination to acquire, accrue and lay bare all available or previously uncovered medical resources at the service of his baby. In contrast, from the earliest days Margrette has been alone in her private acknowledgement of the ineffable and grim possibility of her baby's health not improving. This thought tolls tormentingly and with increasing persistence within her, making her days a living nightmare.

Eventually, though seemingly abruptly, the medical experts present the parents with the likely ongoing and future prognoses for their baby and with the requirement that the parents come to some decision regarding her immediate options. Even at this point, there is some degree of disparity amongst the expert opinions. The majority opinion suggests that Charlotte's functioning would continue to be severely limited though the parents are also presented with an excruciatingly tantalising alternative trajectory which holds out hope for some improvement over the long term. The parents' dilemma is torturous.

Resolution

To move beyond this impasse has required the parents to look at and into the experience of their baby with their fullest scrutiny. Their unique challenge upon entering parenthood has been to not only bond with and come to understand their baby, but to do so within a milieu of medical illness and treatment and to consider her interests both within and despite these medical trappings. They need also to divest themselves of self interest and consider issues beyond the overwhelming sway of their intense love, fear and protectiveness towards their baby. From the sequestered world of the NICU, they now grope desperately towards an opacity of possible futures.

Margrette asks probing questions of the medicos regarding Charlotte's likely future capacities. Would she be able to walk, run or enjoy games? Would she be able to go to school, play with friends, have them for sleep overs? Would she eventually be capable of establishing her own independence, finding a partner, enjoying a sexual relationship? Most basically, could she expect entry into the everyday pleasures and frustrations of an ordinary life?

Margrette also reaches inwards to examine the present circumstances of her baby. She understands that Charlotte is compromised in the most seemingly simple, yet obviously crucial function of breathing and agonises to comprehend the existential significance of this for her baby. Furthermore, she has observed Charlotte come to recognise some sequences within the patterns of her care routines and to display signs of fear and panic as she comes to anticipate forthcoming unpleasant but necessary procedures. Margrette recognises the essential misery of much of her baby's daily reality and the potential for her unfolding awareness to impose a further burden of suffering.

Finally, the mother introspects towards that space of her most inner connectedness with her baby to ask what her baby would now uniquely require of her? Once previously full of fear and doubt, this space now holds layers of primal protectiveness, love, pain, selflessness and ingrained maternal intuition. It is from deep within this space, through having examined all possible aspects of her baby's current and potential predicaments, that Margrette finds the pathway to guide her family towards some form of release.

The intergenerational legacy

MY GRANDMOTHER *YIAYIA'S* ASYLUM-SEEKER BABY

DEAR little Nicholas…
Would that I'd been able to touch him then
It didn't manifest 'til later in life
I came to glimpse it after my visit to Birmingham when I took him a plant in a pot
as a present
and he told me I had to take it away
He wasn't resourced to look after another living thing
Allergic to the responsibility of it
And he'd recoiled
He had his reasons
beyond his control.

WISE Marx his hero knew:
People make their own history
but they do not make it just as they please
They do not make it under circumstances chosen by themselves
but under circumstances directly encountered
given and transmitted from the past
The tradition of all the dead generations
weighs like a nightmare
on the brains of the living [1].
A *Ghosts in the Nursery* [2] thing
You see she was replete with grief herself,
his mother

MY maternal grandmother
managing her own nightmare losses
after first born *Elephteria*
Liberty
died of pneumonia as a baby when they fled
the sacking of the Greeks in Smyrna
1922
She showed me the print of the slaughter when I was four or five
Used to take it out of the old *baoolo* chest at the bottom of the stairs
where she secreted it away from sight
but not from mind
I saw the red blotches of blood spurts and the way the Turkish soldiers were holding the
babies upside-down by one leg as they sliced through their tender bodies with
cutlasses
It looked bad to my little eyes.

I realised
he was imprinted from way-back when an infant himself in the arms of my *yiayia*
ever vigilant
he couldn't help it and I forgive him, my surrogate father,
a baby
in emotional terms himself

FOR hurting me so.

In memoriam Uncle Nick from his loving niece Sophia Xeros-Constantinides Melbourne July 2010

[1] Karl Marx
[2] Selma Fraiberget al., *Ghosts in the Nursery*, Journal of the American Academy of Child Psychiatry, 1975.