Int. J. Prenatal and Perinatal Studies (1991) 119–123

On Premature Delivery, Seen Through the Mirror of Transference and Counter-Transference in Child Therapy

H. Blazy

Institut für Familiendiagnostik und Familienberatung e.V., Köln
Deutsche Gesellschaft für Sozialanalytische Forschung e.V., Köln
Malaiologischer App. im Orientalischen Seminar der Universität zu Köln

Abstract

My talk concentrates on hidden or undeveloped phantasies of children prematurely born and describes a very early fault in communication. During certain sections in therapy with these children I felt a deep and unbridgeable gap between us. In transference they regarded me as a menace to keep apart from or as a neglecting, useless parent who cannot give the right stimuli for development. In counter-transference I was loaden with negative emotional burden. I felt to be the neglected unborn baby in need of communication and understanding, desperately wishing to reach a human being's feelings and to get into a well-balanced inner relationship or to be the mother, feeling guilty of all traumatization done to the baby. The thoughts of Bion on protomental processes and special types of (non)-thinking and communicating helped me to cope with these very desolate situations and to try a "new beginning" in the therapeutic relationship.

Introduction

Since Freud's interpretation of a dream as a prenatal scene in 1933 [1] we know in psychoanalysis about the dynamics of prenatal material in actual life, but it took a long time until further studies on that topic emerged. In the 70th there was a new start: Meistermann-Seeger described the importance of the parental coitus and the maternal orgasm for the fetus [2]. Bion gave illustrations of a "protomental life" prior to be born but in communication with the outside [3]. Raskovsky discussed material on prenatal dreams [4]. Following Bions findings Meltzer de-

International Society for Prenatal and Perinatal Psycholgy and Medicine. Pre-Congress Symposium "Psychological Aspects of Premature Deliveries and Children", Cracow, Feb. 1–2, 1991
Correspondence to: Dr. Helga Blazy, Hermann-Pflaume-Str. 39, 5000 Köln 41, Germany

scribed the fetus at the end of pregnancy feeling uneasy in the womb and wanting to be born, both to escape from the uterine confinement and to make full use of his organs[5]. Like Meistermann-Seeger pointed at "Mania"in the new born child[6], Meltzer as well postulated that birth is not felt as a loss of paradise but as an access already known to something "different, surprising, marvellous – and terrifying"[5]. Generally a mother's capacity for "reverie"as explained by Bion[7] would slow down and moderate the baby's way from inside to outside. A precipitate physical birth would result in a precocious psychic birth, as Frances Tustin[8] formulated since awareness of the ouside world would assail the child too sharply and traumatically.

Case Examples

Because of the short-cut space I can only mention a few aspects of the child therapies here and cannot enter into details of the fluctuation of transference and conter-transference.

Thomas was six years old when he was brought for treatment. He was born two months too early and had to stay two months in hospital after birth. When 1.4 years old he fell from his mother's arm and had to spend a week in hospital with a concussion. When he was three he had an operation. What made me feel strange from the beginning was his silly false stereotype grin. Though he immediately started to play father and mother with me and though we soon could understand that his grimacing and his way of ununderstandable speaking was there to hold back bad words and bad thoughts, his play did not get richer after that. He did not seem to accept any more interpretations. There was no widening thinking relationship. His play activities remained unchanged. Though thinking of Freud's remark that compulsive repetition in children's play is a mean of mastering anxieties associated with trauma, I nevertheless felt helpless with the endless repetitions. There was no emotional contact with the boy himself. He projected hopelessness and depression into me out of some desperate motive of his which should not come to the open. The sessions got flat. When I changed my strategy and told him stories as I felt he had so few, he reacted furiously, shouted at me to stop and threw sand at me. He obviously could not stand to loose control over me. Later on I better understood his refusal of enrichening his own story by symbols as a too early approach. He showed me that neither he nor me were there as whole persons exchanging emotional contact via thoughts. But his behavior changed: He attacked me with fire in a way that made me feel very uneasy, depressed and upset: Smilingly he slowly approached in silence, not looking at me, with burning matches or a burning candle and tried to throw them on me, no matter where they hit me. By these actions we got each other's persecutor and neither could I free myself nor him by verbalizing his burning wishes to melt me so that he could use me or his hatred against an uncontrollable object: me, the doctors he had met, father burning him in the womb during coitus. His sadistic assaults taxed my patience to the limits and I broke off several sessions when he acted against our rule. I felt very bad by my action as an acting out showing my loosing hold of images and of a possible relation. The problem

was: I could not think any more but felt in a vicious circle. Thomas's continuing propensity to repeat his traumas was obvious in his persistent provocative manner. With the help of my supervisor and especially by reading Bion at that time I finally got some deeper understanding of the problem showing up in countertransference. I felt there had to be that acting out from him and me breaking off the session to repeat the traumatic not-in-time birth on another level before we could verbalize the traumatic content. Slowly I regained confidence that we could cope with his traumatic experiences. His sudden unprotected coming to birth had made him acquire a false psychic skin as he showed by his steretype gestures, actions, and speech which stood for protective needs as well as for his experiences in the incubator as a technical lifeless mother with only stereotype actions accompanying his first two months outside the womb.

So for the next sessions with Thomas I asked him to sit on a chair by my side and started to talk to him about what we had experienced together in transference of his birth. For the first time in therapy he listened intensively though showing that he felt very uneasy and he sadly commented with a hoarse voice: "Poor baby is crying." After that therapy with him was not much easier but both of us had got an idea of human relationship with each other which could not break so easily any more. He then retreated for hours behind some furniture as if hidden in the womb and let me start some reverie about the child being there but not yet visible. He just made me hear his breath or his coughing, then some laughing and moving and baby talk not to be understood in words but felt in our emotional context. Thomas's therapy was finished prematurely by his parents when he was admitted to school at the age of seven.

Ben, aged five, came because of stuttering and heavy temper tantrums. He was born six weeks prematurely and immediately after birth was separated from his mother for a month. During the first session he was overwhelmed with fear and cried desperately all the time. Later on he kept close to me while playing with dolls. After about 20 sessions he drew back from contact, refused to speak and to play, hid behind some table and thus told me that I should not reach him any more neither by looking nor by talking to him. Whenever he left his hiding place he suddenly stopped and quite fearfully had to sniff his hands. Many times he desperately cried but could not accept any relief from my side. He was afraid he could take smells or traces on him from the therapy-room to his family world. He even looked carefully at the bottoms of his shoes and sat down to smell them before leaving and started crying when he thought there was left some treacherous trace on him. I felt helpless like him, loosing my imagination, feeling I was nothing but a menacing object to him. He finally refused to enter the therapy-room, so I took a walk outside with Ben and his mother combining his sorrow of smelling strange with his too early loss of his mother's smell and made his mother tell us of how she experienced Ben's birth. That helped all three of us to understand more of the deficiencies he and his mother had experienced by his premature birth and to start working through.

Nino came at the age of twelve because of refusing to speak and tearing out his hair. His head was hidden completely in a big shawl, he refused contact at all. Nino looked like a veiled statue or like a foetus, squatting there with his knees

near to his chin. After some sessions he casually got interested and looked with one eye. Nino was born two months prematurely; a hospital stay of six weeks followed his birth. When Nino was ten years old the parents gave him to a boarding school where his elder brother already managed well, but Nino got more and more absent-minded and depressed, he refused learning, speaking, looking. During therapy he found two ways of expressing himself to me, either he hid behind some furniture some garment over his head or he walked in circles in front of me tearing out his hair provocatively, banning me by looking at me and talking monotonously and not understandably. The latter behavior made me feel very desolate and think of two bizarre objects while his silent hiding transmitted me qualities of a foetus waiting to be touched by the right images to unfold his potentials. One day when running in circles and murmuring he suddenly said he wanted to leave. That was his first clear verbal contact with me. I let him leave the room. When his father came to pick him up Nino turned up from the bushes nearby where he had hidden and told his father he had waited for him already. During the next sessions we could start verbalizing his wish to leave the womb early because of his curiosity to meet his father as a whole person. Nino got eager to think more about this relationship. But at home things went worse due to his parents' opinion. They decided quite abruptly without informing Nino or me before to give Nino to a psychiatric ward.

Discussion

There are several similar traits in the case examples: emotional distance and separateness, withdrawal from contact, splitting the object into bizarre part-objects, projective identification, incapability to symbol formation and thinking, acting out by breaking off sessions or the therapy prematurely. But each case represents a different potential of a child to handle his psychic experience of premature birth. There are not only beta-elements, to speak with Bion, but under the surface of that phenomenon one can discover rudimentary alpha-elements. "Beta-elements are not amenable in dream thoughts but are suited for use in projective identification. They are influential in producing acting out. They are objects that can be evacuated or used for a kind of thinking that depends on manipulation ... as if to substitute such manipulation for words and ideas." Alpha-elements are felt to be phenomena, they "suit to storage and the requirements of dream thoughts"[6], they are produced by alpha-function. If this function is disturbed the sense impressions and emotions remain unchanged. They are like bizarre objects, just bodies, not touched by transformation. During the last two months of pregnancy the foetus acquires protection against external intoxications, and maybe as well a psychic skin through mother's different thinking about her baby as she feels it more weighty in herself and is more concerned with phantasies about the separation of herself and the new being within her womb, giving it a personal face and a voice, a life, a name, and a death. If these psychic preparations cannot steadily go on until birth, there might be some capability lost for both, mother and infant, to communicate in an inner dialogue about leaving each other to meet each other. A premature birth leaves two bodies separated with-

out a psychic bond to overbridge that precipitation, without mutual help as equal beings during that experience. I remind you of Bion's saying: "The mother's capacity for reverie is considered as inseparable from the content for clearly one depends on the other."[7] If she cannot allow reverie, or if it is not associated with love for the child or its father, the child will feel it. "... reverie is that state of mind which is open to the reception of any 'objects' from the loved object and is therefore capable of reception of the infant's projective identifications wether they are felt by the infant good or bad. In short, reverie is a factor of the mother's alpha-function."[7] Meltzer, explaining Bion, applies this thought to prenatal processes emerging in analysis: "In order to introduce meaning into these processes and thereby assist in their elevation into the sphere of symbol formation, thought, judgement and decision, it is necessary that the therapist perform the alpha-function of which the patient is incapable in this particular area of experience. And in order to do this the therapist must be capable of an excursioon of imaginative thought, of dream-thought, that embraces the intra-uterine experience as a 'world' quite different from the 'world' of projective identification."[9] Rhode puts these findings into a broader literary context when saying: "Sanity requires stories to articulate lives. Emotions exist in time and fill a space. The mind needs metaphors as plants need water and air."[10]

References

1. Freud, S. (1933). *Gesammelte Werke*, Bd. XV, Frankfurt 1969, p. 26
2. Meistermann-Seeger, E. (1976). *Gestörte Familien. Familiendiagnose und Familientherapie*. München, pp. 75ff
3. Bion, W.R. (1979). *The dawn of oblivion*. Clunie Press
4. Raskovsky, A. (1970). *El psiquismo fetal*. Buenos Aires
5. Meltzer, D. (1987). On aesthetic reciprocity. In: *Journal of Child Psychotherapy* **13**, No. 2, p. 4
6. Meistermann-Seeger, E. (1986). *Kurztherapie Fokaltraining. Die Rückkehr zum Lieben*. München, pp. 58ff
7. Bion, W. R. (1977). Learning from experience. In: *Seven Servants*. New York, p. 6, 36
8. Tustin, F. (1981). *Autistic states in children*. London
9. Meltzer, D. (1986). *Studies in extended metapsychology. Clinical applications of Bion's ideas*. Perthshire, p. 36
10. Rhode, E. (1989). *On birth and madness*. London, p. 92