3

FINDING ONE'S PLACE

If doctors are meant to be taught leadership skills who is being taught followership skills?[1]

Before giving some descriptions of establishing clinical relationships in practice, some philosophical and psychoanalytic contributions to understanding trust and trustworthiness need to be considered.

Finding one's place in the clinical world

Human relationships are not simply about leading and following. Sometimes they are about being in the same place as each other without the relationship being defined by anything except time and space. Sometimes they are about being together with shared concerns and common purpose. Contending with different relationships involves the development of 'knowing one's place' skills. In clinical practice, this means our place with patients, those in key relationships with them and our colleagues. The question posed above was not derived from a belief that doctors should be leaders. It was a challenge to colleagues to realise their place in clinical teams.

Finding out about our place in people's lives and their place in ours involves empathy: 'The power of mentally identifying oneself with (and so fully comprehending) a person or object of contemplation' (SOED). In the medical context, Zinn (1993: 306) describes it as

> a process for understanding an individual's subjective experiences by vicariously sharing that experience while maintaining an observant stance. It is a useful tool in the medical encounter as it provides the physician with a fuller, more personalized view of the patient, and it provides the patient with a sense of connectedness to the physician that may allow him/her to more freely express his/her emotional distress.

It is highly significant that Zinn defines to it as a 'process'. Making an 'empathic statement' is not an end-point after which one can tick a box to state 'I showed empathy'.

'Fully understanding' is an excellent *aspiration* but probably an unrealistic *expectation*.[2] In fact, more realistic is an ability to convey a depth of *appreciation* of the other, a sympathetic awareness and tolerance. 'Appreciation' may be present without true understanding and even in the presence of misattribution. Embedded in this empathic process are unconscious processes through which both parties are able to learn to accept and live with imprecision. Despite the best will in the world, there will be areas in which there is no understanding, incomplete understanding or even misunderstanding. From a psychoanalytic viewpoint, 'identification with' is more complex than the definition conveys. The psychodynamic mechanisms involved can achieve a sense of 'something shared' but it can also contain '*somethings* merged': this process may have contradictory effects – avoiding any sense of total alone-ness but denying individual identity. This will be considered later in the book (see Chapter 10).

The empathic clinician also needs to be a person whose actions are appropriate and in whom individuals and society can have confidence. O'Neill (2002a) believes that there has been a societal 'crisis of trust' including in health care. Different qualities may be accorded different values by each party in relationships. Trusting another person involves 'accept[ing] vulnerability to another's possible but not expected ill will (or lack of good will) toward one' (Baier 1986: 235). From the psychiatric and psychodynamic point of view we can expand the idea of 'ill will' to include 'illnesses of will, thoughts, and emotions'.[3] Such illnesses can set the scene as one of dis-ease and misattribution and lead to actions in the sufferer or those around them which cause further dis-ease and misunderstanding.

Trust and trustworthiness rely on a sense of not simply being tolerated but of being appreciated for the qualities one has. This is an acceptance of abilities, inabilities and vulnerabilities and being treated with *kindness* in the sense that it is derived from *kinship*, of having certain basic human needs and wishes in common (Philips and Taylor 2009). Trusting means expecting that others will respond to these, and take them into account in what they do even if the outcome cannot be what was desired. Health in relationships means accommodating and being accommodated.

Tony (*Clinical example 2.4*) believed IRA terrorists were seeking to harm him. He was in a hypervigilant state and behaved unusually. This produced concerned responses in those around him: these responses were frustrating for him. Briefly he was able to consider that he might be mistaken in his beliefs. With that came a sense of utter humiliation and a crisis of trust in the extent to which he should trust his own judgement rather than that of another person. Both scenarios were threatening but ultimately something threw him back to trust his own judgement of being in danger from the outside world. Tony could not continue to 'accommodate' an alternative view and to be in two minds. In responding to him, I had to appreciate his position and simultaneously accept that he might not think me trustworthy because I did not agree with him.

Most clinical practice does not take place in situations where there is such a profound disruption of trust nor the presence of beliefs of the nature of Tony's. However, in working with children and their parents, two factors need to be taken into account. Developmental factors mean that beliefs, actions and emotional responses that would be considered unusual if they occurred in an adult are normal in a child or adolescent. States of anxiety and hypervigilance can lead to regression to earlier modes of mental functioning (see Chapter 2) in adults as well as in children; this is especially pertinent in considering parental responses where there is concern and responsibility for their child.

Becoming established in the clinical setting

For any medical student, stepping into the clinical setting in their new role is a landmark event. It provokes a multitude of emotions including anxiety. The student has to manage these to be sufficiently at ease to learn about this new role and to learn in this new role. Along with being aware of what they have learnt, students will become acutely aware of how much they do not know. They face challenges about attitudes and values as well as knowledge and skills. They have to feel confident that it is legitimate to be part of the lives of patients upon whom they rely for their learning. What might otherwise appear a selfish pursuit of personal ambition is essential for all of us if we are to have doctors to look after us.

Becoming established in a paediatric setting brings additional challenges. Despite having been children themselves, it may feel like an alien environment. It brings with it the complexity of managing relationships with less assistance from language or presumptions of shared understanding; it also means always being involved with their patient and a third party. In response to this, I introduced seminars for students to consider communication from a developmental perspective.[4]

Students were given a brief introduction to the task which was to understand more about children's experiences of hospital and their modes of communication by spending some unstructured time with a child in the clinical setting. They were instructed to arrange a suitable situation for the meeting and to have some drawing and play materials available. If they did not already know the child, they were asked to have an appropriate adult introduce them. They were told to explain that they were learning to be doctors and would like to spend some time with them. No notes were to be taken while they were with the child, but they were asked to write down as much as they could remember afterwards and to bring their notes to the seminar. The aim of the instructions was to provide a general structure to facilitate while minimising constraints. Some students found the lack of specificity difficult to consider but were usually able to accept my explanation that it needed to be left open in this way to explore the subject properly.

Tutorial example 1

At an earlier tutorial on child protection, the student who presented the following material had already shown herself to be astute and thoughtful in discussion of a baby and its mother. She told us the mother 'was the sort of woman who, if you were taking a photo of her holding her baby...she'd be looking and smiling at the camera not at her baby'.

For the assignment, she had seen a five-year-old boy. She already knew him as she had been present the previous evening when he had been admitted with a severe asthma attack. He was now almost completely recovered. He was an intelligent precocious child whom people initially found charming but who had by this time irritated everyone with his imperious attitude. The student knew she had to prepare the assignment and despite some misgivings, she decided to approach him.

She introduced herself politely as a medical student, but he totally ignored her. She thought she had nothing to lose so spontaneously tried a different approach. 'I'm not really a medical student, I'm really a Red Indian squaw and my pigtails have been cut off.'

The boy stopped in his tracks, captivated. He immediately told her he would draw the person who had done it. During their conversation he developed the story, producing further drawings to say it was a monster who cut things off people. He went into great detail. The student and the child both took great pleasure as he spontaneously developed his story with this unintrusive, playful and facilitating young woman.

The seminar discussion considered issues relevant to five year olds generally. I proposed an explanation in psychoanalytic terms for the boy's response to the comment about pigtails being cut off, and his obvious fascination with the perpetrator. I suggested it stemmed from fears about bodily integrity. We discussed possible links with his asthmatic experiences. At the end of this I referred to the way the student had been able to engage the child and suggested that without realising it she had registered something important for the boy. I went on to describe how the feelings and reactions brought out in us by our patients can be examined to see if they may give us further information which might prove useful in assessment and treatment.

Tutorial example 2

Two students from different groups described a situation where the children they selected, a four-year-old girl and a three-year-old boy, had

been wary about becoming involved with them although their reaction did not make the students feel they should withdraw. In both cases the children slowly responded to the sensitive interest shown and seemed to enjoy their contact with the students. In describing the ending of their time with the children both students independently and spontaneously said they had felt bad about it. They felt their process of engagement with the children had been in the form of offering a relationship but that in the end they were simply withdrawing, 'shutting the door'.

Tutorial example 3

An adolescent with muscular dystrophy, an intelligent boy of 13, talked easily with a student about his interests and his disease. He knew other boys with muscular dystrophy whose condition had deteriorated and they had died. Finally he asked 'Will it kill me?'

In the seminar, the student asked 'What do you say?'

Tutorial example 4

Sometimes different groups discussed the same child.

One student was with a four-year-old boy who was suffering from a chronic and potentially fatal disease. Staff were finding him difficult and irritating to manage. On this particular occasion he kept asking the nurses where his mother was. He was told she had just gone down the corridor and would be back soon. In fact, the staff knew she had gone shopping and would be away for some time. On her return the mother gave the boy the same explanation as the staff. She then began showing the staff the things she had bought, talking about them and her trip whilst standing at the foot of the child's bed.

In the next group of students, one described a contact she had with the mother. Whilst she was sitting writing some notes, the boy's mother began a conversation with her. Another patient's mother came up and started talking about something completely different with the first mother. No attempt was made to include the student or to continue or complete the original conversation. The student felt she was being treated as if she was not there and she described the confusion and feeling of impotence this created in her.

In the first of these seminars we discussed the problems for the child in coping with being told lies and then having this compounded by

hearing the truth being told in front of him as if he was not there. We discussed the possible implications of this in relation to his ability to trust adults and the relationship to his difficult behaviour. This led to different students giving different parts of the history of the impact of this boy's illness on the whole family. The mother had been told that her son was going to die during the first acute episode of the illness two years previously. She had been able to tell one member of staff that in one way her son had died for her then. Unfortunately she had not been able to accept any more personal support and referral to the child psychiatric team had been turned down. I suggested that this mother was behaving towards the child in part as if he was dead and went on to the issue of the staff responding in the same way. Possible causes of this such as the difficult emotions aroused by working with chronically ill and dying children were then touched upon.

With the second group, having discussed the student's experience and something of the child's illness, I related the information from the previous seminar. I juxtaposed the position of the child in the first incident and the student in the second. I suggested that perhaps the student's experience might give us a better understanding of what the boy was going through. Perhaps his irritating and overbearing behaviour was a way of trying to cope with the emotional turmoil inside himself as a result of this illness and relationship with his mother.

Tutorial example 5

A male student had found himself in an awkward situation.

He had been with a doctor and nurse who were admitting a six-month-old baby to the ward. The baby was suffering from an acute respiratory infection. Her mother was with her but needed to go home to make arrangements for her other children so she had to leave her baby at that point. The doctor had already left and the nurse told the student she had to attend to something else and asked him to stay.

The student said he was not used to babies but finding himself alone with a screaming infant lying in a cot, he had to decide what to do. He sat down next to the cot. He thought the baby was frightened of the situation and of him so he did not try to engage her. He simply observed her through the bars of the cot. She carried on crying but this very gradually began to decrease in intensity. He noticed that she occasionally looked briefly towards him. Eventually her crying stopped.

She then started playing with her toes. After a little while, he touched her fingers and toes; she started playing with his fingers. She then engaged directly with him and he picked her up. The sequence had lasted about 45 minutes. He stayed with her and described her smiling and laughing with him.

The material presented illustrates the powerful challenges and potential of an approach which is based on observation, respectful participation and reflection. Students reported and reflected on having to manage outside their 'comfort zone' in terms of their knowledge, emotional experience and previous experiences of relationships, realising that powerful emotions such as fear, sadness and anger will be evoked. Finding a place for these feelings is essential to avoid disruption of their learning. This requires a learning culture and teaching environment which provides proper respect and support for students in assimilating and processing their new experiences. This, in turn, means teachers engaging in the same processes and having the expectation that their institutions will support such an environment (Tan, Sutton and Dornan 2010).

The students demonstrated respect for the children and acute awareness of the possibility of themselves being a threatening presence (*Tutorial examples 2* and *5*). What they were not so aware of was their potential positive value to the children. I had not originally anticipated this but it became apparent to me from the first tutorial and manifested repeatedly. In *Tutorial example 1*, I suspect the student's spontaneous response and subsequent interactions with this boy may actually have had a therapeutic effect, changing a situation from one of repetition of responses to his defence activity to one in which playfulness could process persecutory experiences. In *Tutorial example 5* I suspect that what could have been a profoundly upsetting experience for the baby became one in which she was able to emerge with an experience of her all-but-overwhelming experiences having been contained. Without setting out to be 'therapeutic' the students had offered something akin to Winnicott's (1971a) descriptions of 'therapeutic consultations'. Indirect benefits also arose from the enhanced understanding of the children and their families which it was possible to feed back to staff involved with their care. This was particularly valuable when it was possible to work as a co-tutor with a paediatrician.

The world of the infant

he infant is born primed for awareness of the presence of another person. his expectation of being in a relationship has been termed *intersubjectivity* tern 1985). It sets the stage for a developmental trajectory manifesting the

presence or absence of trust and empathy (Trevarthen and Aitken 1994). In psychoanalytic theory this is referred to as *object relations* and various aspects of this have produced intense debate and divergence of views (Likierman 1995).

Klein postulated states of 'paranoid-schizoid functioning' in which 'understanding' is not a governing principle issue (see e.g. Segal 1988). Processes of projection and identification (Chapter 1) leave room only for two states – 'safety in sameness' in contrast to 'danger in difference'. This is also a world in which there is no sense of absences. If the source of what is desired and experienced as needed is not (objectively) present it is experienced instead as its opposite. It is present but persecuting by withholding what is desired or needed. This is the concept of the *absent object* (O'Shaughnessy 1964). Hunger can be experienced as the presence of a mother who withholds herself and food. With maturation it becomes possible to realise that hunger continues but that there is a not-yet-here-but-wanting-to-feed mother. In states of paranoid schizoid functioning there are no gaps in understanding. Instead these are filled with attributions derived from internal and external cues assimilated into an imaginative life. Recurrence of such experiences later in life gives psychotic experiences as illustrated in *Clinical example 2.4*. For Tony there was no awareness of the IRA being 'recruited' to fill the gap which would otherwise have occurred through not being able to make sense of everything his senses were telling him.

Kleinian theory presents a developmental trajectory of maturation from experience which includes a significant degree of paranoid-schizoid functioning through to an awareness that there are a variety of contributions to experience from the different people involved in relationships. This development includes a sense of having contributed to the state of affairs through one's own wishing and feeling, longing and loving as well as hating and feeling destructive. Klein called this stage *depressive position* (Hinshelwood 1989) which can be confusing since it does not actually refer to depression in the sense of sadness or 'clinical depression'. Winnicott (1963b) took a different position although still building on the underlying framework. He viewed the change as being one of developing a *capacity for concern*. What the baby requires is sufficient experience of their most intense experiences of being contained and harm avoided. Winnicott embodies this by talking of 'holding' rather than containment (see Abram 1996: 183–9). The best foundations for healthier development are laid by the provision of the basics for life along with a necessary and sufficient degree of adaptation and attunement. This ability in the primary carer (mother) and those others available to support her and her baby is crucial in promoting emotional development (Murray and Andrews 2000; Murray et al. 2011).

The philosophical and psychodynamic consideration of trust and primitive states provides a framework to consider how relationships become established and used to promote 'understanding' in its fullest sense. Knowing our place as clinicians in people's lives involves applying our knowledge and

training in the service of our patients. In doing this we have to ensure that our personal interests – our inquisitiveness, our need to learn, our need to earn a living, our wish to be recognised by others – are neither obtrusive nor intrusive.

Making things add up in relationships

Some years ago I was watching a sports programme which was part of the coverage of Wimbledon tennis tournament. The presenters were discussing the different practice and expectations of commentators. They illustrated this by showing two commentators watching and listening to a BBC broadcast and then discussing it. The excerpt showed the two leading players involved in an exhilarating rally. It seemed impossible that either should have been able to return the ball let alone produce a further challenge to the protagonist. This was accompanied by the gasps of the spectators and the silence of the commentators. At the end, one of the commentators simply let out an exclamation of admiration and appreciation. The observing commentators simply could not understand the sound of silence.

Winnicott was interested in the processes of people being able to experience what is happening without needing to feel a sense of agency in the immediate situation and in being able to resist any impulse unhelpfully to make themselves agents. He was a master of the enigmatic aphorism and summed up the importance of this ability as 'after being – doing and being done to. But first, being' (Winnicott 1971a: 85).

Appreciating our place in other people's lives is a fundamental indicator of social development. Our place may be in deciding to be present or absent, to make things happen or not to make things happen. By extension, Winnicott is also interested in how it is possible to be with another person without necessarily being observably, actively engaged with that person. He called this 'the capacity to be alone' (Winnicott 1958: 30). There is a paradox in this in that 'this experience is that of being alone, as an infant and small child, in the presence of mother'. Thus the basis of the capacity to be alone is a paradox; it is the experience of being alone while someone is present. The essential ingredient is the capacity to act without the need to involve the other person in doing something or to provoke an experience in the other – making her feel she has been 'done-to' – in order to carry on with the activity. This indicates a degree of equanimity in terms of there being neither conscious nor unconscious pressures from either person: it is a state in which the processes of projective identification are not called upon.

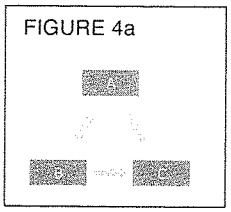
The sports commentators who were observing their colleagues did not appear to have attained this 'capacity to be alone'. Or perhaps it would be truer to say that they had not been able to maintain it. They were driven by a need to feel they were creating the viewers' experience. The BBC commentators were able to be there, ready to enhance the experience but able to be

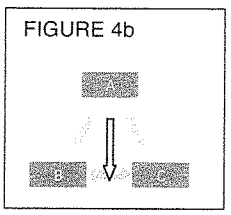
present alongside others as co-observers. The observing commentators, driven by the imperative 'Don't just *sit* there, *do* something!', were not able to follow a different imperative 'Don't just *do* something, *sit* there!' The observing commentators might have argued that their employers required them to 'do' something, and that the action of their colleagues would have been a 'breach of contract'. But their need (for employment in a culture which wants immediate, immediately identifiable impact) takes precedence over serving to enhance experience.

Developing an ability to manage what happens inside us as practitioners in observing our patients is essential. Knowing when action is required and knowing when 'externalising' (i.e. observable activity) is not required both require mental activity. Deciding which is required and in what balance at which time can come easily to some people and less easily to others; it is a factor in all practice with children and their carers. It becomes particularly critical in working with mothers and babies and in general when using psychoanalytic approaches. For this reason, infant observation is a requirement in psychoanalytic psychotherapy trainings and can be beneficial for all work with children (Miller et al. 1989).

Contending with the relationships between other people and finding one's place with them includes finding oneself as an observer to their relationship. Stern (1990) pointed out how three-person relationships actually involve six relationships, If we consider three people, A, B and C, then we have relationships of A to B, B to C and C to A (Figure 4a). In addition we have A in relation to B's relationship with C (Figure 4b) plus the same for the other pairings. So, any group of three people automatically involves at least six relationships (Figure 4c).[5]

The recurrent theme is that by placing ourselves in professional roles we inevitably put ourselves in situations of increasing relational complexity. We create the possibility of the emergence of feelings, thoughts and less easily identifiable experiences which must be managed. Failure to do so may have serious consequences for our patients and ourselves. In addition to the countertransference issues described in Chapter 1 we have to develop the ability to manage ourselves in relation to the relationships between other people.





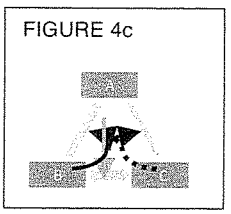


Figure 4

Mothers and babies

the ordinary course of events, at the centre of the process of birth and puerperium are two people who are adjusting to a massive reorientation reorganisation. During pregnancy a mother has been able to do all her by needed simply by looking after herself properly but now she has to ply herself differently to her baby's needs. Becoming established together quires confidence that she and her baby are suitably equipped to survive and ive and in her own ability to provide what is needed for their 'equipment' function. The experience can be a pleasure and a pain: the quality and ensity of experience, unique. Awareness of what she can now do for her by opens the way to realising and learning more about her own abilities. e can also be faced with an emergence of fears that she may not have it herself to do what is needed. Accompanying this may be the stirring up conscious or unconscious fears that she will do harm. Winnicott (1956a) scribed this period as *primary maternal preoccupation.* The mother's needs d the baby's needs are so intimately linked that they are inseparable to the tent that 'There is no such thing as a baby ... if you set out to describe a by, you will find you are describing a *baby and someone.* A baby cannot exist one, but is essentially part of a relationship' (Winnicott 1964: 88).

As clinicians our first responsibility is to respect this by being available participate if needed and to ensure we do this in the least intrusive and trusive way possible. Only in situations of particular need, for example lness in mother or baby, should there be need to come between them. When is necessary, any interventions should be mediated as far as possible through ose who are and will continue to be in the most important relationships, for xample fathers, extended family.

Beyond staying alive and in reasonable health, perhaps the most important hing a mother can do for her baby is feed her. The evidence is that the enefits to be gained from breastfeeding in terms of physical health in the hort term and through life far outweigh those of artificial substitutes. Yet in he UK breastfeeding rates remain poor.[6]

Where recommendations exist relating to other areas of child health, ny experience is that practitioners appear to feel free to be vociferous, and ven strident, in their views and efforts to see that they are adhered to, for xample parents who decide not to immunise their child may be openly riticised. Yet the growth-promoting and health-providing benefits of breast milk over artificial formula feeds do not appear to produce an equivalent esponse. The supply of a mother's milk is responsive in part to her baby's needs. If an artificial mechanism was found for replicating this would there be any hesitation in recommending it over currently available alternatives? This is a highly complex area but in the present context I want to consider if psychodynamic factors may affect whether health practitioners robustly apply evidence-based recommendations.[7]

There is a proper concern for mothers who might not be able to breastfeed for any reason and full and proper account needs to be taken of their position. But these women are not so numerous as to govern general policies rather than ensuring the provision of high-quality, individualised care. Paternalistic health practices have been challenged and the importance of personal autonomy and choice has come more to the fore. But personal autonomy and choice do not necessarily make good bedfellows with parenthood – particularly not where the care of babies and young children are concerned. In fact, the ways in which the ordinarily devoted parents' welfare and sense of well-being are dependent on their child's welfare cannot be underestimated. Winnicott (1956a: 308) again captures this: 'when we are able to help parents to help their children we do in fact help them about themselves'.

The factors involved generate heated debate despite the scientific evidence. The factors influencing breastfeeding being chosen and supported are multiple (Raphael-Leff 1991: 551). In clinical practice, advocating it wholeheartedly may be inhibited by professionals recognising that their training is insufficient for the task or that the opportunities to fulfil the role adequately are limited by other demands. However, faint praise or reluctance to be an advocate may tip the balance and rob a mother and baby of something beneficial.

Where infant feeding is concerned, I have observed many professionals switch into a different mode, sharing either that they did not breastfeed or that they found it difficult. My impression is that this happens more readily than in other areas of practice. As a man I am freed from having any personal experience of being a breastfeeding mother. But if I had that experience would I use it explicitly with reference to it being what happened to me and how I handled it? Sharing may be an enlightened attempt to correct perceived power imbalances and to enhance a lay-mother's self-esteem; sharing a difficulty in order to demonstrate that clinical expertise does not confer expertise in personal life. But a problem shared is not necessarily a problem halved. It may undermine recognition that this mother does have it in her or that very different contingencies apply to the situation. It offers a spurious authority reminiscent of the UK government minister who fed his child beef to prove that there was no potential problem of infection with vCJD.

Brandell (1992: 35–44) highlighted how a professional's *identification with the patient* may come into play unhelpfully and how it needs to be distinguished from what can properly be attributed to the patient's transference or projective processes. In psychoanalytic theory acknowledgement or denial of difference plays a crucial role (see for example Segal 1988); the corollary is that unconscious envy can be a particularly powerful force in the countertransference. It can be a manifestation of deprivations, of awareness of dependence on what others possess and one's dependence on them. It can stem from longings and resonances with good experiences in the past that cannot be regained, of Paradise lost. Identificatory processes pre-empt acceptance of difference. They may feel like the forging of a respectful partnership but

rather than respecting autonomy it may unwittingly undermine it. They 'manage' something in the immediate situation and deal with the unprocessed and unconscious experiences which the practitioner brings. The patient looks after the professional.

The feelings evoked in being with a mother and baby can lead to an unconscious enactment of envy which manifests as a need to be a prime actor in feeding the baby rather than a facilitating influence. Inability to tolerate the pain or frustrations that may be experienced by mother or baby may lead to premature interventions in feeding, undermining the potential of the relationship between mother and baby to be realised. A fathers' involvement in the care of their baby has to take account of this: being a father should not be equated with being simply interchangeable with the mother and any wish to be involved in feeding should not come in the way of what the baby needs. He has a key role as the first representative of the persistence of the outside world beyond the foundation relationship (eee for example Abram 1996: 169–71). Neither should fathers be used simply as a repository for projections of envy – assuming they will feel pushed out or envious rather than accepting their experience of a multitude of emotions as they play their part in the new relationships that are forming.

For all these reasons many organisations involved in training those who may be involved with new babies and their mothers in their feeding relationship are required to go through a process of 'debriefing' their own experiences and being able to demonstrate they have assimilated them in a way that will not intrude into their patients' and clients' lives.

When special care is needed

The range of conditions which would previously have been incompatible with life in newborn infants but which can now be treated has risen enormously. Care of premature babies has expanded to such an extent that new challenges are faced in medical ethics and law in deciding when the rights of 'personhood' are confirmed. With these new advances come new challenges to parents and professionals to understand not only their use and applications but also to attend with the experience of them being applied. McFadyen (1994) has written about the care and development of relationships of babies admitted to medical special care bay units and neonatal intensive care units. What follows is an account of my work with some child psychiatrist colleagues, who were at the time nearing the end of their specialist training, in a related type of unit, a surgical special care baby unit (Surgical SCBU).

Developing relationships: the value of research in child psychiatric liaison

The Surgical SCBU in St Mary's Hospital, Manchester, recognised very early in its establishment the importance of an holistic approach to the families of infants admitted to their unit. The staff were particularly concerned about

the long-term adjustments of the families and the babies. And this led to the establishment of *family care nurses*. These posts were at senior level and served to bridge the gap between hospital and home, assisting parents in the sometimes highly complicated tasks involved in the care of their babies. I received a request from the unit for some teaching about the experiences of parents whose babies were on the unit over a long period of time. I did not have specific experience in this arena but what was as important in deciding what to do was the fact that the request for teaching could be understood as a referral for help with a 'systemic symptom'. The information I was given indicated that this had arisen as a new area of concern because some complicated situations had arisen. I arranged a process of initial 'consultation to the system' rather than a simple teaching exercise.[8] I arranged a series of meetings with nursing staff to better understand their work and the various issues arising from this. I also met one of the mothers; this was arranged on the basis of asking for her assistance in helping us understand more about the issues for parents when their child is on the unit for a long time. The meetings highlighted four particular areas:

1 Communication problems between staff within the same discipline, between staff of different disciplines and between staff and parents. Added to this were complexities consequent upon the various permutations, for example information communicated to a parent by a doctor might not be given to nursing staff directly from the doctor but rather by the parent on the basis of the parents' understanding and/or misunderstanding.
2 Some babies' problems altered from being those of acute surgical/technical care through to becoming 'long-term' nursing and infant care without the baby being well enough to be discharged. At this point there was a clear change in relationships between parents and nursing staff. During the acute stage the primary influence on the nurse–parent relationship was in terms of technical expertise and, in this respect, nurses were experienced as being more or less interchangeable. However, as the babies became 'long term', the individual personalities of the parents and staff were more significant for the relationship: the 'fit' was more important. The result was that clear preferences would arise in relationships and, as a consequence, the potential for rivalries and conflicts.
3 The powerful forces at play in (1) and (2) in the context of infants with such serious or even life-threatening illnesses created a situation in which the conflicts were more likely to be experienced or enacted.
4 The depth of concern and thought about the issues of relationships for babies and their parents was impressive; the request for child psychiatric involvement was a demonstration of this.

My preferred response would have been to offer ongoing consultation to the staff group; however, child psychiatric resources did not allow this possibility.

Instead I wrote an open letter to the staff describing my observations as outlined above. There remained the opportunity for any specific family who felt they needed child psychiatric assessment to be referred through the usual routes.

Through learning we teach

An opportunity subsequently arose for a period of detailed work with the Surgical SCBU through a fortunate combination of events. The unit identified a further area of specified need. Simultaneously two trainees with appropriate sub-specialist experience and allocated time for clinical research developed an interest in this area. Below they describe finding themselves in a new clinical world.

Dr Smith

As a senior trainee on the ward round in the paediatric medical ward I expressed interest in a baby, Josh, aged two months whose mother was objecting to the use of a dummy/pacifier in her care. Nurses explained that Josh had had surgery to his throat and been tube fed. They felt that the dummy would help him to learn to suck. I spent time with the mother and realised the impact of her son's feeding difficulty upon their relationship. We agreed to keep in contact. Over the four months that followed I had eight meetings with Josh and his mother. He had a complicated surgical course and I found myself drawn into my first conversation with the surgeon and the surgical nurses about the impact of a feeding problem on a developing mother–child relationship.

In this time with Josh and his mother I had to come to terms with the intrusive presence of the monitors. Josh had frequent respiratory arrests. (I was greatly relieved that he never stopped breathing during my sessions.) His mother talked with me about her feelings for the baby and how the technology of the monitor had a particular role in her awareness of her baby.

This close encounter with a mother and baby in crisis was the beginning of my relationship with the neonatal surgical team. I was both interested as a doctor and a psychiatrist and at the same time shocked by the experience. As the mother became an expert about her baby's condition, I too learnt from her. As a child psychiatrist I felt perplexed by the extensive network of highly skilled people and expensive machinery surrounding a developing mother–child relationship. I was unsure of my role and with my colleagues decided to capitalise on a model of liaison developed in Manchester by Professor Elena Garralda which forges links through joint research into the

psychological experience of patients and families. This made sense in a psychoanalytic model; research is seen as seeking understanding within a relationship with paediatric staff. More pragmatically it offered a route forward as time for research could be protected from clinical demands.

Dr Jones, a fellow trainee, joined us in an embryonic research group. Her interest in mothers and babies establishing their relationship had also emerged from direct clinical work with a mother and her seriously ill baby:

> 'Over the course of about a year I had to work out where I fitted into a new way of working in parent-infant therapy. At the same time I had to contend with my feelings of not knowing about babies and their illnesses.'

We tentatively approached the surgeons with a plan for research with the aim of finding out how a child psychiatrist can contribute to the assessment and care of newborns with congenital abnormalities which can be treated by surgery. The surgical team were keen to establish this. It was agreed that in selected cases where they felt there would be benefit, mothers would be offered a consultation with a psychiatrist. They thought this would help us to establish our role in the unit and to develop our ideas for research.

The task of planning our involvement was a consultative exercise in itself. Dr Smith and Dr Jones met with the surgeons and with the nurses several times during day and night shifts to discuss with them what we hoped to do and to seek their views. This began the establishment of a working relationship. It enabled our role to be distinguished from that of the social worker who potentially could have become involved with any of the babies. Dr Jones was struck by the parallels between her experience of learning about parent–infant therapy and the emerging clinical research process:

> 'In the same way, in approaching this project we were needing to learn how to fit into this strange new world that we had discovered. We quickly become aware that the surgeons and the nurses had their own separate areas of expertise, in the theatre and at the cot. But we did not know where our expertise might lie.'

At first we were surprised in our conversations with the surgeons at the artfulness and creativity that went into the operations. Operations were done that were not described in any textbook but were an individualised response to a particular baby's anatomy. We had not realised how similar surgery could

be to psychiatry in having to deal with uncertainty and not-knowing. Our initial feelings of ignorance carried with them anxiety which decreased as our questions were responded to thoughtfully and respectfully. It appeared to be a relief to the staff that questions could be asked and answers sought. Thus it became a shared endeavour of seeking to know what it was really like for these parents and their babies on the unit and if child psychiatrists could be useful to them.

The Surgical SCBU was like a world in itself, perched, constantly lit, atop the hospital tower. Nurses sometimes felt they were not part of the normal hospital life, forgotten and not noticed even though the lights were always on. There was a powerful sense of paradox of being isolated yet on display. The nurses echoed the feeling expressed by one mother about her baby's simultaneous isolation and public display in his incubator. This mother was able to recognise that her feeling was not only what she thought her baby would be experiencing. It was her own experience of being with her baby, at times with him but at others isolated from him in the presence of other people. Whatever she did it could be viewed by other people.

Below are some representative comments from consultations with mothers:

> 'They took me down to the SCBU... It was shattering. She was in an incubator, I was in a wheelchair... I couldn't touch her... I was totally drained. He had things sticking out all over: monitors; a tube up his nose ... mucus coming out of everywhere – mouth, nose. I couldn't believe that that was mine.'
>
> 'He just looked at me and I loved him. I just wanted to forget that this was happening.'
>
> 'I thought "it's a bad dream, someone's going to wake me up". She just didn't look normal ... Normal babies, they look contented or cry. She just laid there.'
>
> 'I only saw him once before he was taken to St Mary's. I only held him once. I didn't have energy for a proper cuddle. All this equipment everywhere. Nothing about him looked right ... it was terrifying.'
>
> 'It just didn't seem like she was mine. Everything was unreal. Where was this perfect baby we'd expected ... I had this tiny thing that didn't look very well ... I suppose without realising it I switched myself off from the baby...'

We came to understand how the issue of display and intrusion were interlinked. For the nurses our presence was another form of people being put on display. At first some had been suspicious of what child psychiatrists may be doing on the unit – one nurse asked if we were analysing them. We learnt a lot from informal conversations with nurses and parents, often 'over the cot'. Dr Jones describes a specific episode:

> On one occasion I watched a baby having his nasal passages sucked out by a nurse using a plastic tube and a suction pump. The baby was squirming and his mother who was watching closely looked uncomfortable. But the nurse handled the procedure in a professional way – without looking uncomfortable and being useful and efficient.
>
> The procedure although minor and routine was invasive for the baby. I was aware that I was feeling invasive just by being there and witnessing this activity and the mother's distress. This reminded me that I could indeed be invasive for the mothers by my physical presence. I could come to see them on the ward whenever I wanted to but the ward became their home – several mothers had stated that home is where their baby is. I realised I needed to learn to allow the mothers to *not* want to see me sometimes.

The problem of ensuring good communication was one with which we could help:

> One mother was very anxious that her baby was not putting on weight. She thought he may have malabsorption like her husband's sister. She had tried to ask the surgeon if he would transfer the baby's care to a physician. She thought that would enable the baby to have tests or treatment that he had not had. However the surgeon did not think that was needed and the mother's anxiety remained unresolved.
>
> The nurses saw this as the mother having had an opportunity to talk with the surgeon, but for some reason, not wanting to listen to him. The nurses were feeling inhibited about discussing the issue further with her because they in turn were anxious about an aspect of her mothering that they had observed. They thought that the mother was interpreting her infant's difficulty in feeding as wilfulness or naughtiness. Mother would tell her baby not to be naughty when he had difficulty feeding, and the infant was described as 'good' by both nurses and mother when he was feeding well. Thus a moral dimension had been imposed and the infant was presumed to have some self-will in this domain.
>
> When I went to meet with the mother, she seemed relieved to talk and said almost immediately that she was worried because the nurses were calling her baby naughty. She said she realised that he was not being either naughty or good, and it was annoying her that the nurses were making such presumptions. The issue therefore raised itself naturally. She went on to explain and think about her feelings that the surgeon was being over-possessive of her baby.

It was as if the surgeon did indeed have ownership of the baby. He had maintained his life and the mother had 'merely' brought the baby into the world. Her fear of the surgeon's perceived wish to possess the baby prevented

her from pressing her point and she had remained anxious and dissatisfied. But she had been unable to say all this to the staff; she explained to me that she did not want to be critical when they had done so much to help. This cleared the air for discussions and the reasons for misunderstandings and difficulties in relationships were themselves understood. Trust and confidence were restored.

This situation also brought out the appreciation of infants' individual characters and how far they were recognised as individuals by the nurses. We saw that with the key nurse system as far as possible the babies and their nurses know each other. Being a key nurse gave permission for an individualised concern for the babies. It also led us to consider the different aspects of the nursing role – one aspect akin to a 'primary maternal preoccupation' (Winnicott 1956a), the other a 'primary surgical preoccupation'.

Concern for the individual was an area that we thought we would like to consider in detail in the interviews with the mother. We were interested in how her concern for her baby's individual experience was manifest. We thought it would be reflected in the current state of the mother's mental organisation and her thoughts and feelings regarding attachment. For example, a mother said that when her baby looked at her for the first time she knew that he was telling her that he wanted to be held and cuddled. She was able to do what she could for him by stroking the back of his head and said that when she did that he knew he was being cared for.

The full complexity of what could happen was emphasised in the situation of a mother who had had a multiple birth: two of the babies were very seriously ill and had to remain in hospital while the others were able to go home.

Dr Jones

Six months after delivery one baby was well enough to go home to be with the rest of the family. The nurses then became worried because mother did not seem to spend much time on the ward and was arriving later and later.

Mother explained to me that she did not feel right when she was away from home because she missed the babies who were at home so much. She did not feel right when she was at home either, because she missed the baby that was in hospital.

For the next meeting, Mother brought in a photograph of the babies who were at home. She stood it beside the baby in hospital while we talked. She said that for the first time she had all her babies in her mind together. She was able to describe her feelings of love for her ill daughter, how beautiful she was, how she enjoyed touching her and looking into her eyes, how she missed her when she was not there and how she felt relieved and comforted to see her.

The conflict between fear of isolation and freedom from intrusion is profoundly complicated. There seemed to be a particular value in our role as people who came into and left this mind-boggling world of lights and sounds and vulnerability but who were also accepted as a non-intrusive presence. Being this 'someone else' for mothers did seem to facilitate them in finding it possible to be alone and establish themselves more with their babies. Usually this process of getting started together is an intimate partnership between 'being with' and 'doing to': doing can make easier the process of being with when it might otherwise become too difficult. They had to be able to tolerate other people doing things to their baby and their babies' consequent distress. These mothers had to find a way of containing their impulses for action in the face of not being able to do the usual things for their babies. They had to learn about their babies in the context of their baby's 'not-doing' and mutual responsiveness not being possible in the usual way.

Dr Jones

I watched a mother struggling to play with her month old and very ill baby who was unable to respond. It is very hard to get the balance right between being too stimulating and not being stimulating enough. In that case, it was frustratingly impossible for the mother to enable normal development to take place in the abnormal environment. She expressed the conflict between her longing for escape from that environment and her baby's dependency on it: she wished she could steal her baby away with her in her shopping bag – but she knew if she did he would die.

The observations here have come out of using a model based in a particular form of participant observation. It attends very carefully to maintaining awareness of the different clinical roles and the place of being authorised to observe and offer a commentary. We helped parents to understand their feelings or actions and help them to regain a sense of coherence which facilitated their relationship with their infant. We assisted staff to understand why a particular parent is feeling or behaving in a certain way. In addition to the work with mothers, individual nurses discussed issues that concerned them such as the need for privacy in bereavement and the difficulty of accepting death. We were able to go beyond the 'primary surgical preoccupation', helping nurses and mothers in understanding their role and what they can do.

Summary and conclusions

Entering the world of clinical practice is a developmental milestone accompanied by events and processes building on previous qualities and learning

and opening up new possibilities of what we can do and what can happen to us in this process. Becoming part of other people's lives through our professional role opens us up to things about ourselves as well as about those other people who look to us at particular times of need. This is never more so than at the start of life when mothers and babies are becoming established together. It requires a particular sensitivity to the impact we may have on others and the impact they have upon us. A fundamental respect for autonomy, dependence and interdependence combined with an openness to learning provides a sound base for the emergence of trustworthiness and for our patients, their parents and colleagues to have confidence in us. Such trustworthiness is the platform from which good clinical practice and research can emerge.