

Vladimir Lipovetsky, M.D.
www.drLipovetsky.com

MEDICALLY COMPROMISED INFANTS AT BIRTH AND BEYOND
(Adapted from an article published in *Los Angeles Psychologist* in
November, 2007)

Little is known about emotional sequelae which accompany both pre-term and other medically compromised children into adulthood. Up to twenty percent(8) of newborns spend time in a neonatal intensive care unit (NICU) due to being medically compromised. Abundant data show that at least for low birth weight babies their cognitive and psychological development is affected by the early compromise(8).

Newborn individualized developmental care and protocol (NIDCAP) is an empirically validated approach to care of pre-term infants. It improves outcomes of inpatient treatment and development of neurological structures responsible for mental regulation(1,9). Not much is known about effects of NIDCAP on outcomes in later childhood. Even less is known about subtle emotional derailments of development which follow early compromise. I report here on a technique for assessing and addressing the needs of medically compromised infants.

Newborns who require NICU stays include those with very low birth weight, premature babies, those that require surgeries, and those who are suffering from or suspected of having life-threatening illnesses. During their hospitalizations, they experience innumerable challenges to normal development and attachment. They are separated from their families for long periods of time. They pass through many sets of hands, all different. They experience the drama of resuscitations of other babies or their own. They are exposed

to the distress of the staff and of other babies. They undergo invasive or painful medical procedures. And in the end, they may suffer irreversible damage to their bodies. All this is profoundly challenging for full-term babies, and much more so for infants who are not ready to be out of the womb.

Thankfully, advanced technology and devoted staff allow most NICU babies to survive, and months or years later, many will play like any other children. However, as many as half (3,4,8,9) of the very low birth weight babies, many of whom are also premature, will have developmental and psychological difficulties detectable even at preschool age. Ironically, as more medically compromised children are born, and most of them survive the initial ordeal, there may well be more and more of them requiring mental health treatment. And when they are being treated, what therapists will know what it is like to be intubated while having no capacity to comprehend why it is being done? What does a baby do with an experience when she is screaming and no scream comes out (when the breathing tube passes between vocal cords and prevents sound from being made)? What does the echo of this experience look like in an adult or a teenager or a small child? We can make guesses, but do not, at present, know.

Two years ago, I met a lively 4 year old boy, whose parents were in marital therapy with me. At the time of the transition into preschool, he developed an aversion for wearing shoes because they "hurt" him. His father remembered the child's hospitalization in the first month of life, where his heels were repeatedly stuck to draw blood. I encouraged him to share these memories with his son. The boy listened to the story with rapt attention and asked for it to be repeated about a dozen times in the next few days. His aversion to shoes dissipated shortly thereafter, never to return; he is now aged 6.

In his case, a thoughtful, attuned witness was available and helped the boy overcome one hurdle. How many children will be fortunate enough to have this kind of attention? In Los Angeles, a group of mental health clinicians (THRIVE program), of which I am a member, has been using a psychoanalytic method of infant observation in a neonatal intensive care unit.

The goal of the observation is to discern the infant's experience. Compromised babies do not necessarily communicate their states the same way that healthy full-term babies can. As a result, the clinician has to be aware of very subtle changes in behavior, mental state, and physiologic arousal. She or he must also monitor the environment, counter-transference, and intuition. The clinician's understanding of the infant's experience can then be used to inform the care. The interpretations can be shared with the nursing staff, with the parents, or with the parent-infant pairs.

This kind of understanding has been used by pioneering psychoanalysts in Sweden to work directly with mother-infant pairs(5,6). It has also been used in a number of hospitals in Paris to help babies transition from a biological mother to adoptive parents and to speak to babies who fail to thrive.(7) NIDCAP, while much more focused on objective signs than the psychoanalytic observation, also aims to provide care to pre-term infants based on their discerned internal experience. So there is an increasing confluence of interest in infant's experience from from neurodevelopmental and psychoanalytic fields.

The research on NIDCAP confirms that individualized care, which is attentive to babies' limitations in handling arousal and contact, markedly improves inpatient outcomes and neurodevelopment. This makes for healthier babies who are more available for bonding and for return to normal

development. But this protocol is designed mostly for premies and few hospitals implement it because of enormous restructuring and investment that it requires.

This article does not even begin to address the broader implications for parents, extended families, siblings, social services, and schools.

While clearly more needs to be known about emotional, neurological, and relational development of infants in such dire straits, there are reasons to believe that careful emotional contact, and a relationship informed by it, can lead to strengths in a new person that otherwise may not arise.

Bibliography

1. Als, H, et. al. (2003) A three-center, randomized, controlled trial of individualized developmental care for very low birth weight infants: medical, neurodevelopmental, parenting, and caregiving effects. *Developmental and Behavioral Pediatrics*. 24(6), 399-408.
2. Als, H., Lester B.M., and Brazelton T.B. (1979). Dynamics of the behavioral organization of the premature infant: A theoretical perspective. In Field T.M., et al. (eds). *Infants Born at Risk*. New York: Spectrum, 173-192.
3. McCormick MC. (1992) Advances in neonatal intensive care technology and their possible impact on the development of low birth weight infants. In: Friedman SL, Sigman MD, eds. *The Psychological Development of Low-Birthweight Children*. *Advances in Applied Developmental Psychology*. Norwood, NJ: Ablex Publishing; 37 – 60.
4. McCormick MC. (1993) Has the prevalence of handicapped infants increased with improved survival of the very low birth

weight infant? Clin Perinatol. 20, 263 – 277.

5. Norman J. (2001) The psychoanalyst and the baby: a new look at work with infants. Int. J. Psychoanal, 82, 83-100

6. Salomonsson, B. (2007) Talk to me baby, tell me what's the matter now. Int. J. Psychoanal 88, 127-46.

7. Szejer, M. (2005) Talking to Babies: Healing with Words on a Maternity Ward. Beacon Press, Boston.

8. Vohr BR, Wright LL, Dusick AM, et al. (2000) Neurodevelopmental and functional outcomes of extremely low birth weight infants in the national institute of child health and human development neonatal research network, 1993 – 1994. Pediatrics. 105, 1216 – 1226.

9. Developmentally Supportive Care: Hospital to Home. Family Infant Relationship Support Training (FIRST) Conference. July 26, 2007. Encino, CA