
Attachment with Children with Special Needs

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Abstract

The paper, initiated by personal experience, looks at the fear of attachment to children with conditions which put them at risk, the experiencing of grief at the loss of the 'fantasy baby' and the acceptance by the parents which enables the attachment to proceed.

Reference is made to attachment issues in the case of adoption, styles of attachment, and some notions of reconstruction in therapy with 'special needs' survivors where attachment has been insecure or the process attenuated by length of risk.

'Of all the obstacles that confront a new mother, learning that her child is not completely healthy can be the most staggering.' (Stern, 1998: 182)

Thus begins the chapter on children with special needs in Daniel Stern's new book *The Birth of a Mother*. He comments that the normal, imaginative playing out and reworking of the future and its place in the landscape of the mind of an expectant mother, is brought to an end with the severe shock at the recognition that a handicap of some kind does exist—an 'end to the future' as it was going to be. Some time after the successful operation to close the palate of my baby granddaughter, Ailsa, I gave my daughter Julie Stern's chapter to read. After some minutes she looked up and said "Mum, how does he know me?"

In June 1997 we were all caught in the present, and unable to go on elaborating the future. With the words "She's a lovely, lusty girl, just a little hole in the roof of her mouth" the house surgeon handed me the little blue bundle I was anxiously waiting to hold and as I took her, the busy sounds of the theatre staff finishing off the necessary Caesarian operation faded into the background. The rush of my eagerness suddenly tripped and shuddered to a halt. Inside my mind a voice said "Damn it, why ... ?" as I felt all the readiness to love, adore and attach to the little person suddenly gather up inside almost physically and twist into a tenseness that would not recede for many months, and still can return to haunt me. Immediately the absolute thrill of being able to phone my husband was tempered

with a stabbing consciousness that by this phone call I was about to wound a lot of dear relations and friends as well as relieve them with the news. Not knowing the extent of the cleft at the time was possibly a good thing as they, like me, could be let in on the gravity of the situation piece by piece—as happened in the next few hours. Foggy from lack of sleep over the last two days, and sitting with my drug-fuddled daughter, Ailsa's father Stewart and I heard the paediatrician explain her condition at length. The timing of this was inopportune—he left a bemused family behind.

Joan Cornwell (1983) says:

The birth of her first baby precipitates the mother into a sudden and massive loss of identity. She is no longer the woman she was before the birth. She does not know who she is, having not yet acquired her new identity as mother. Her bewilderment and aching sense of loss are joined to a realisation of her total responsibility for this live, helpless baby despite feeling utterly incompetent for the task. She herself feels like a newborn baby, suddenly vulnerable, exposed, unheld. The father too experiences this same loss of adult identity. He may feel like a lost little boy, faced with a situation beyond his competence.

How much more so when something like this adds confusion.

A summary of the doctor's information is as follows: Pierre Robin Sequence is the condition where in development the palate has failed to close due to a failure of the tongue's descent from posterior positioning and micrognathia or short jaw is the result. Much variation of opinion about causes exists from hereditary and genetic factors, to growth disturbance affecting maxilla and mandible, uterine position, and lack of amniotic fluid so that the jaw does not float free. It was also suggested to us that sprays inhaled or ingested by the mother at a certain time in pregnancy could be implicated. The operation to close the palate could not be done until nine months – and an operation to splint her jaw and bring it forward might be needed. It would be necessary to have her on an apnoea monitor until she had matured enough for the tongue not to block her airway and risk choking.

After the doctor had gone, little one was bathed and the naso-gastric tube replaced and a small feed was given. When mother and baby had settled for the night, Stewart and I went home and listlessly ate scrambled egg while having a slightly acerbic exchange: he objected to the doctor naming it as a 'condition' and I, who had not said it was, tried to say that I had heard what the doctor had to say as if indeed it was one, but fortunately eminently curable at nine to ten months. I now see that I was trying to overcome his necessary defence in the circumstances by using one of mine. He needed to survive by denial at that time; I have been trained that understanding is the key to surviving crises.

The days of hospital visiting and staying overnight to support my daughter melted into one: helping Julie learn to bath baby (a politically correct and tooth grinding experience, watching Julie's terror and the reluctance of staff trained to 'let the mother find her own way' to tell her what to do – which eventually I could not stand

and interfered as the shivering baby waited to be wrapped up); changing the tube; trying to express; trying to feed and giving up; many visits by medical people with various opinions and information. My daughter was becoming bewildered and angry and was struggling to assimilate it all.

As a developmentalist, my overriding thought was — what does it do to attachment if the handicap is so much to the fore that she can't see the real baby? How will she discover who baby is and how will baby discover her? How will I? Will I be given the opportunity? In my fear I was uncomfortably reminded of the time 35 years ago when my son choked at two days with unaspirated phlegm, and I thought for an agonising eternity that he had died as he was not returned to me for what seemed like hours. How was I going to live with a threat so similar for many months when I would be three hours' drive away? The little heart monitor winking its messages was our constant companion. With all the fear, empathy was a struggle and huge unspoken questions hung over me about my daughter. Would she neglect the baby? Would she go and try to leave the baby at the hospital? No-one said anything of this at the time, although I discovered later how worried the midwife, social workers and nurses were, not to mention my son-in-law who was pulled into fatherhood full time by the amount of attention the little scrap needed.

The special kind of a bottle and teat needed for a cleft palate baby requires strong rhythmic squeezing which squirts milk to reward the biting, which was all that she could do, and, of all things, both my daughter's hands were disabled by pregnancy-related carpal tunnel syndrome—a sort of double-whammy in the circumstances. Thus the baby's arrival and subsequent needs caused physical pain as well as emotional maelstrom, and for many months both parents argued over when to give up the slow intake (of perhaps forty mls of mixture from the bottle) and revert to siphoning the rest of the feed by tube. (A constant overfeeding may have been in progress, Ailsa's only defence being the forcible ejection through mouth and nose of the just ingested milk, which could happen three to four times a day.)

After many sleep-fractured nights I had to return to my 'babies' in Auckland and as the young couple had established something of a co-operative routine, I had to be content with that. They had the support of the midwife, social worker and Karitane nurse, (for which, thank goodness) as these were all visiting Julie and observing her behaviour as well as Ailsa's, as they were as concerned as I was. I visited as I could, driving to Rotorua and back, watching the agonised removal and replacement of the naso-gastric tube—tricky if parents have no experience and have a dislike of things medical; watching the feeding which seemed only just over when it started again; listening to their frustrations and bitter comments to each other as the baby slowly pulled them into parenting; knowing how wounded in self identity they were both feeling but not saying; and listening to the self-recrimination as the discussion of possible causes went on. Two other babies were born at that hospital in the same month with this 'sequence'. One novel notion was that agricultural sprays may have caused it, as all three babies were in utero on farms during the Christmas thistle spraying. (There is no way to prove this, of course.) Genetics, mutations and developmental accident (big father,

short mother with large baby), all sorts went on –‘somehow someone must be responsible’.

The worst of that was the feeling of defectiveness which led to deep despair and anger in the ‘white nights’ when my daughter, tortured, sleepless and angry, sat watching the monitor blink, terrified in case it stopped or the alarm went off. Only later did she tell me that even the baby’s father, exhausted as he was, did not know that her nights were so spent. But in that time ‘attachment’ worked its magic too; ‘the two way street’ (Stern: 193) was in action. Despite the pain and the unnecessary guilt, the process of making the ‘stranger more familiar’ which having a handicapped baby accelerates (out of the extra physical needs and procedures as well as the psychological) was growing and burgeoning. At the same time, their marriage was having to be ‘re-invented’, their caretaking roles defined and the acquisition of other support systems took up a lot of time and shortened patience.

There is a good case for saying that this whole event is a lengthy set of traumas resulting in post traumatic stress syndrome, complete with flashbacks, recurring dreams, distress and reactivity on exposure to these, guilt, avoidance, detachment from others, restricted range of affect, irritability, hyper-vigilance and exaggerated startle response. Fortunately those who cared for the family over the next few months were able to integrate diverse opinions, encourage, support and nurture so that the circumstances were calmer and more conducive to the growth of love and attachment, until finally Julie was able to say that although Ailsa was not the daughter she wanted, she was “the one she wanted now”.

Understanding Attachment

Turning to attachment concepts, I would now like to say something about a way we used to look at bonding and attachment. It was said that ‘bonding’ (whatever that was), was a process that happened soon, if not immediately, after birth. The inference was that within hours or at least a few days, a ‘bond’ would have occurred between caretaker and baby. In his earlier work *The nature of the child’s tie to his mother* Bowlby (1958) had explained the notion of attachment to a discriminated chief attachment figure, using the analogy of the phenomenon of imprinting in which young birds will attach to any mobile figure to which they are exposed at a sensitive period in their development. (This analogy was later revised as not so applicable to humans.) However attachment, unlike imprinting, was a process which was much slower, requiring several months. It gave adopted, premature and ill babies some kind of ‘second chance’ — the infant remained ready to ‘attach’ if some inappropriate ‘bond’ may or may not have taken place, for example, to nursing staff, to an object, or to the birth mother rather than the adoptive mother.

I think we now have a much clearer way of seeing this process, largely due to the influences of John Bowlby, whose monumental work *Attachment* (1983)

stemmed from his earlier paper, and of those who followed him in attachment research and writing, which of course continues presently. Attachment theory accepts the customary primacy of the mother as the main caregiver but nothing in the theory suggests that fathers are not equally likely to become principal attachment figures if they are the carers (Holmes, 1993). Recently Alessandra Piontelli (1992) discovered through studying the scans of pregnant mothers while they were in progress that a huge amount of attachment is already taking place under possibly less than ideal conditions. The fantasy which used to be elaborated by about four to seven months and was modified towards the full term of most average pregnant women so that the sex, appearance etc., would not be too far at variance in truth as in fantasy, is now elaborated by being actually 'seen' in action as it were. It is now possible that many opinions and interpretations are often made thoughtlessly and projectively by theatre staff and patients alike. Previously a 'kicking' baby was thought of as being a 'footballer' or 'ballerina', now there is evidence visible to support this, albeit distorted, projection.

Patterns of Attachment

These distortions add rich fuel to the fantasies of mothers who already unconsciously have representations of several types of attachment pattern according to their own mothering. Three common types according to Mary Main's research are the dismissing, enmeshed and autonomous patterns.¹

A *dismissing* attachment pattern (described by Stern, 1998: 42) comes into effect with a mother to be who is not particularly interested or involved in reflection about her own past. It may be accompanied by personality traits which are congruent with that, such as avoidance of issues expressed or unexpressed. This mother keeps her distance from feelings and appears to be less absorbed by the thought of a coming baby, at least on the surface.

An *enmeshed* attachment pattern is that which is present in women who become so involved that a clear perspective on what is happening may be impossible. They may be women for whom separation and individuation have not fully occurred from their own mothers and are normally deeply involved in actively maintaining the enmeshment.

Autonomous attachment is that occurring between mother and baby when mother has the ability to reflect on processes between herself and

1. See account of Berkeley Adult Attachment Interview in Karen, 1994: 365–379).

her baby, as well as those between herself and her mother, in a balanced way where neither process dominates.

Already in the uterus, with connection to feeding and elimination processes through the umbilical cord and placenta, much is happening. The chemical compositions of bodily fluid in which the baby is bathed are familiar, the interchange processes are an unthought given, and the dim external world with its repetitious happenings is familiar also. The shocks of the unexpected may make a baby 'leap in the womb', but the procedures like the body of his mother becoming vertical each day, the bumpy vertebrae that push at his space when she lies down, the sound of her voice and others, the even beat of her heart above his head, are all commonplace to him. He is born, whatever way, ready to increase and proceed with the attachment process.

Attachment Issues in Adoption

Something important may be said here about adoption. From Nancy Verrier's book *The Primal Wound* (1993) there is important awareness to be gained from the recorded feelings about babies separated from the already familiar at birth or just after: a procedure that was rife thirty years ago, but fortunately much less in force now, except in much more unusual circumstances and hopefully with more informed adoptive parents. Those of our patients who have been adopted children and have lost that sense of self already formed and connected with their birth mother are sometimes in grave need for us to understand the small 'psychic death' which has occurred in them as a result.

Hofer's paper (1983) proposed a unified theory in which attachment behaviour develops with the biological regulatory processes hidden within the mother-infant interactions. In this the loss of mother not only evokes psychological responses but it also has a direct impact on the body due to the withdrawal of the previous biological regulations supplied by the mother, and this modification of systems may influence later susceptibility to disease.

This relationship has been beautifully expressed in the *Autobiography of a Baby* by Pat Hunter:

I have moved through panic to desolation. I need to be with my mother. She needs to be with me. She does not allow me. In this desolation I know this which I didn't know before. She needs my love. Without it she cannot love and feed me. I need to love her. I cannot love her from my emptiness. I want no-one else. I do not cry out. My desolation is better than the pain of their

touch. I speak to my mother soul to soul. But my words smash against the iron door — shut against them. I cannot enter. (1989: 15)

We need to work with this as imaginatively and sensitively as possible so that the grieving of that 'self' who died and reformed as another may be completed, rather than haunt their lives producing difficulty in behaviour and relationships.

Attachment and Self-Regulation

Metcalf and Spitz (quoted in Taylor, 1987: 122) suggest that the 'psychic precursors of dreaming commence during this switch-over period (the first month of extra-uterine life) and the beginnings of recognition memory indicate the rudimentary psychic structures are being formed'. Research has since confirmed that the infant is 'a highly organised creature who seeks out and regulates incoming stimulation and engages actively with the mother, who he can discriminate as a recognizable, specific object by two weeks'. (Stern, Emde & Robinson, 1979, quoted in Taylor, 1987: 15). Stern cites the experimental situation where adequately fed infants will continue to suck on an electronically bugged pacifier in order to make the carousel on a projector change slides after scanning. He thinks that infants have 'optimal levels of stimulation below which more stimulation is sought and above which stimulation is avoided' (1983: 10). This indicates that self-regulation is an in-born capacity which is met by the mother in an interactional system, thus organising self-regulation from birth, shifting gradually from physical to psychological levels as the infant becomes increasingly aware of being separate.

Condon and Sander (1974, quoted in Taylor, 1987: 125) found that neonates synchronise their movements exactly to the rhythm and structure of speech. The intuitive repeating rhythms of rhymes and word games which parents use with babies attract this response, and there are many different patterns of attention, action, and affectivity present at two weeks (Brazelton et al., 1975, quoted in Taylor: 125). Modification and adaptation continues between the two over time, in increasingly complex and diverse ways, and self-regulation, due to the influence of both, will ensue as the two enter into and emerge from states of separation and attachment.

Hidden processes as a biological as well as a behavioural modifier include the mother's role as outside homeostatic regulator for nutrition, warmth, holding and handling. Animal studies have proved that heart rate in baby rats is regulated by the amount of milk the mother supplies (Hofer & Weiner, 1975). This regulation is moderated by autonomic and central nervous systems and

not by circulation. It may not be possible to extrapolate a similar influence for human babies yet, but it is well known that the baby's suckling stimulates the mother's oxytocin flows which influence the production of milk. In experiments with sleep-wake rhythms and the regulation of growth hormone with baby rats, their mother's separation caused a fall in blood levels which was raised by reunion. Separated infants also become apathetic and depressed after the initial 'protest' response described by Bowlby (1969). Rocking, patting and other movements normally provided by the mother may well appear in a stereotyped automatic way when human and monkey infants are deprived of this.

The transitional object described by Winnicott (1953) may go some way toward the continuation of regulation in the face of anxiety evoked in mother's absence. The infant's own creation of emotional dependency on a specific chosen object like a toy or soft blanket provides an illusion of 'oneness' at the same time as awareness of separation. Winnicott suggested projected feelings and meanings of the infant imbue the object with representations of mother and infant, through smell, touch and taste.

In his overview of the more recent research on psychology and neurobiology of the mind, Allan Schore (1994) proposes a model of the ontogeny of emotional self-regulation. His thesis is that:

the early social environment, mediated by the primary caregiver, directly influences the evolution of structures in the brain that are responsible for the future socio-emotional development of the child... The resulting variety of dyadic affective interactions between the caregiver and the infant is imprinted onto the child's developing nervous system. Different types of stimulation are embedded in these 'hidden' socio-affective interactions, and they elicit distinctive psychobiological patterns in the child. In response to such socio-environmental experiences, hormonal and neuro-hormonal responses are triggered, and these physiological alterations are registered within specific areas of the infant's brain, undergoing a structural maturation during a sensitive period. (Schore, 1994: 62-63)

He further proposes that

despite the changes in object relations over the stages of infancy, the mother's constant self-object role as an external regulator of the child's internal affective state is essential in providing the infant's limited nervous system with the modulated stimulation that optimally enhances the growth of its own affect regulating structure... These experiences are stored and can

be accessed and regenerated to regulate the emotions, even in the mother's absence. (Schoore, 1994: 62–63)

This experience has been named by Stern (1995) as the 'evoked companion' or, 'the recalled memory of being-with-another', which has been constructed by the infant forming a representation of how he feels within himself while being with the other in that way.

Holmes (1994) reminds us that Klein and Bion discussed the modification of phantasies resulting from rage by the soothing presence of a parent. In the past Bowlby himself had said the restoration of proximity to the discriminated figure is central to the Attachment theory. An aggressive or retaliatory mother who is unable to accept the child's anger may leave it harbouring phantasies of revenge, and with a self-protection which may appear as indifference or avoidance of these. Bowlby saw loss as central to disturbance and the importance of mother in neutralising the destructive effects of rage in response to loss. He also saw the use of affective withdrawal as a defence against unmet longing or anger faced alone.

The insecure attachment resulting from these unmodified states was named in two groups in Mary Ainsworth's research into the Strange Situation (1978) which can be summarised as follows:

Insecure avoidant – children who show few overt signs of distress on separation, and ignore mother on reunion; they are however watchful of her and limited in play.

Insecure ambivalent – children who are distressed and not easily soothed by mother's return, seek contact but resist it, pushing away or refusing comfort, angry and clinging.

(*Insecure disorganised* is a third category more recently described and is a confusion of the previous behaviours, with stereotyped movements and 'freezing' behaviours).

The Centrality of Empathy

What would be the outcomes for my granddaughter? Would the anger Julie felt make her unable at times to receive (as a container) and modify the projections Ailsa would be making? I had to remember that Ailsa did not know any other way to be in the world with her parents – knew no reason for her tube rather than breast or bottle, or the terminals for the monitor that were pasted to her body. She was not left alone except when asleep and she was ready to go on attaching. What she was up against was the fear and frustration and grief of her parents instead of the relaxed confidence they both expected to grow into. For her the soothing

presence was not available while one or other was worried or angry (or they both were, with each other).

There was however an obvious empathic quality which showed that they knew how she felt when in pain and discomfort, and the requirement of her lengthy feeding and attention meant that these times were compensated by many cuddles, smiles and just the determined gentleness that both tried to show as much as possible. It was not uncommon to find Julie sitting up asleep with Ailsa's sleeping head on her shoulder for hours at a time. The soothing presence was there and as time passed in those first few months her trust in being able to use both their bodies for comfortable sleep grew. Both were distressed most of all at the tube changes as they had huge fear of hurting her (grappling the unconscious wish to retaliate). Yet it seemed there was ability to act as 'auxiliary egos' for her, 'feel into' her experience at times and respond sensitively enough despite their exhaustion and despair.

During those months I was with them enough to observe and hear plenty about the professional help which was available. It seemed that there is now a good level of understanding and teaching going on with the professional bodies represented in this help, but the quality of the individual's ability to offer and act on the understanding was often questionable. The best help Julie experienced came from a young Karitane-trained Plunket nurse who visited and sat quietly and listened to Julie while holding Ailsa for an hour a week. I watched her carefully observing Ailsa's and Julie's interactions. She couched requests for information on how things were in the context of conversation, so that Julie was reasonably unaware of supplying it. She was attuned to them both in an unusually mature way not often seen in those from other disciplines.

Many of the other helpers were preoccupied with external issues, whereas the young Plunket nurse seemed able to acknowledge for Julie how difficult the balance was between her doing her best and feeling so guilty and angry.

Cornwell (1983) says:

The pattern of feeling inadequate as a mother when the baby is suffering, and then dealing with this by the baby's ability to feel, or trying to be reassured by obtaining the knowledge of the baby's satisfactory development in weight gain or increasing motor skills, is seen repeatedly by observations of mothers with young babies. It is very difficult both to acknowledge and tolerate the feelings of persecutory guilt and yet continue to struggle to do one's best. (p. 30-31)

In a case which began two years before this personal experience, I encountered M who was having relationship difficulties. She told me how when D, her son, was born he was given six months to live. With a double cleft palate and multiple heart defects it was thought better if his mother didn't visit him. Her husband handled the whole thing with flippancy as a defence which made her feel dreadful. Despite the hospital's discouragements she did however visit D

to feed him but felt afraid of getting close because he might die. He didn't and M lived in hospital with him for three months. The danger of his operation was very real, with two resuscitations necessary in the course of the operation and for eleven months after it he was fed through veins. At eighteen months although undernourished he was able to learn to sit with the aid of a physiotherapist. The repair of his palate went well but persistent pneumonias threatened his recovery. M stayed in hospital with him—recalls that by his third year he was admitted only three times. Because of his condition he went to a special school and was given speech and occupational therapy. Mainstreaming was tried but he became depressed therefore needing the care of a special unit. With the strains ongoing his parents parted when D was six. At seventeen he still has the aorta in the wrong place and three holes in his heart. His attachment to M is strong. Recently he had quite an Oedipal challenge when M started to see a new partner, but has survived that and while dependent has achieved much.

Insecure Attachment

Access to the emotionally responsive mother engenders a secure attachment, an expectation that homeostatic disruptions will be set right. On the other hand the mother's incapacity to act as the infant's psychobiological regulator specifically defines a growth inhibiting environment. Securely and insecurely attached infants express different patterns and capacities for affect regulation during proximal separations and reunions with mother. The mother of the insecure 'avoidant' infant experiences contact with the infant to be aversive, and the child reacts to this by avoiding the painful and vacillating emotions aroused by her. The mother of the insecure 'resistant' toddler *inconsistently* allows contact at reunion, that is, she *partially* participates as an affect regulator. This is experienced by the child as an unpredictability, and interferes with leaving her in order to explore the surrounding environment. (Schoore, 1994: 384)

The insecure avoidant child then avoids the misattuned disorganising stimulation it expects to emanate from mother's face. What follows is a limited capacity to experience intense positive or negative affect, and conservation withdrawal. The insecure resistant infant is in a mixture of approach and avoidance (ambivalence) in response to mother's facial expressions and cannot resist the unpredictable eye contact. Winnicott (1971) expressed this saying that such a baby quickly learns to make a forecast: "just now it is safe to forget mother's mood and be spontaneous, but any minute mother's face will become

fixed or her mood will dominate and my own personal needs must then be withdrawn otherwise my central self may suffer insult". (p. 113) For the insecure avoidant the development has occurred in the parasympathetic system strengthening the withdrawal. For the insecure resistant the sympathetic system dominates, causing the personality to manifest intense emotionality and susceptibility to under-regulation, just as the avoidant is susceptible to over-regulation disturbance, being disabled in regulating sympathetic arousal. Grotstein (1990) has explained the role of the right hemisphere in mediating the processing of more primitive emotion, and considers that a limitation in one attachment pattern or over-stimulation in the other, may be inefficient in modifying, adjusting and monitoring the more 'primitive mental states'.

In reunions after attachment ruptures, psychobiologically attuned mothers of securely attached infants act to re-regulate the child's arousal level back to a moderate range, for example, through distress-relief sequences or 'interactive repair' (Tronick et al., 1989, 1990, cited in Schore, 1994). Adler and Buie (1979) proposed that this representation is able to be evoked from memory as an image of comforting object and function in the mother's absence. This image is a multimodal or averaged image of the mother's face during interactive repair interactions. The mother of an insecure infant does not engage in interactive repair in distress relief. This may mean the infant is stuck in unmodulated negative affect and therefore inhibited, perhaps permanently, in the development of the very systems of hormone production which enable motivational and cognitive processes.

Developmental deficits, previously thought of as arising from traumatic activity suffered by the child, are now able to be conceptualised as traumatic 'absence' (or unrelieved negative affect) resulting in deficits (Lansky, 1992) arising from deprivation of empathic care creating a growth inhibiting environment, and thus immature and vulnerable regulatory systems, in which narcissistic rage and humiliated fury are unable to be modulated.

The reparative value of therapy in adulthood is that the therapist is prepared to attune empathically and carefully reconstruct the past with the patient. Not only is the verbal narrative taken into account but the pre-verbal which is always there waiting to be 'interactively repaired' or modulated, so that internalised negative affect may be transmuted at last.

After many months, finally Ailsa reached the required weight, and on a windy February afternoon I met the little family when they arrived at Waikato Hospital.

Ailsa and mother were to be admitted for her operation and Stewart and I were to be 'support staff' and stay at the nearby hostel.

The tension that night was palpable and despite all our efforts we could not sleep. In the morning we all accompanied the little cot through the rabbit warren of corridors to the theatre floor. Julie carried Ailsa to the prep room for the first anaesthetic, returning in tears, devastated at watching her go limp. We waited and walked and returned and waited some more till nearly three hours later the doors opened and the high pitched noisy crowing breathing of the little one emanated from the cot as it was wheeled to the intensive care unit. With her learning to breathe with an unfamiliar obstruction in her mouth the next six hours were terrifying; watching the heart and breathing recorded in winking lights, cuddling her when she cried (very awkward with about eight leads attached to her body in a tangle). However the amazing skill of the surgeon working in such a tiny space was underpinned when he came to check her and announced that the second operation would not be necessary. The tissue had been sufficient to close the hole. (Daughter nearly fainted at the news: for a moment they nearly had a second patient!)

The next week went by in a haze of walking up and down the corridor with Ailsa in pushchair or in arms, speculating what to try to spoon or syringe in when she wasn't looking, wondering if she would ever go to sleep (she was suspicious of letting herself because of the nasty things that had happened before), dozing in the armchair or watching while both mother and baby slept, exhausted.

However with the surgeon's blessing, and protesting about the cones tied on her arms to keep her from putting her fingers in her mouth, Ailsa and the rest of us then travelled back to Rotorua. Days and nights were extremely unsettled. We took turns to be up while the others slept, and watched videos of Barney the purple dinosaur many times in the night with Ailsa when nothing else would calm her. She was soon able to consume increasing amounts of food again, however, and after a couple of nights where she slept five or six hours at a stretch, I left them to it and came back to Auckland, as they were well resourced with Plunket and social workers for help. Since then Ailsa has gone from strength to strength and we are very thankful.

When I look back to the many months of travel back and forth and with the level of fear and anger I was holding, I often wonder how I was with my clients. In some ways having a heavy case load was a blessing in which I could submerge myself in responding to them in the work we did together. I do wonder however about some who were deeply in their own fears and griefs at the time and were particularly responsive to me and may in fact have spared me more than I knew. Certainly I am aware that for some of my long term clients, their own work has moved quite quickly this year compared with last, and their state of 'interactive repair' is now fully evident as I have been able to relax much more.

In Kestenbergs' paper (1972), discussed by Theodore Jacobs in his book *The use of the self*, she states that it is between the ages of three and five that memory fragments are organised and gain meaning, although in later phases they

become more elaborated by the then prevailing ideational content. As the young child organises his nonverbal memories under the guidance of his parents who supply the words and structure, he is bound to delete or distort what his parents themselves deny or repress.

Despite Piaget's position that no evocative memory of early childhood exists, some researchers since have suggested quite differently. Piaget thought that sensorimotor function was built by physical action and not available to 'internal manipulation by the infant'.

Lichtenberg (1983) had made a case for function as perceptual-affective-action mode in the first year, without use of symbols within mentation and therefore unavailable to interpretation in analysis.

Later research by LeDoux in rats, found that the thalamo-amygdala circuitry in the brain processes simple sensory cues, and it may be in these that the memory traces are stored prior to cognition. This may help substantiate the view that 'emotional memories' are stored very early in a raw form, unintegrated. Share (1994) speculates that there may be a parallel with Bion's (1962) beta elements here or Freud's (1923) 'perceptual image'. Terr (1988) in her work on trauma stemming from the memories of the victims of the Chowchilla kidnappings, found that the significant age for registering and later retrieving a verbal memory of their trauma was two and a half to three years. But strikingly in post-traumatic play the children often played or re-enacted parts of the whole experience. The "mirroring of traumatic events by behavioural memory can be established at any age, including infancy". (Terr, 1988: 96)

Share (1994) cites the research of Stern and Nachman (1984) where 75 six month old infants were subjects of an experiment to show a capacity for evocative memory of affective experience with two puppets. One which evoked a laugh initially, evoked a smile one week later. The other which was neutrally responded to at first evoked neutral response one week later. They conclude that:

Our finding suggests the presence of a memory storage system, including affects, that are recallable by cue very early in infancy, long before the emergence of a language or symbol based semantic recall memory system. (Share, 1994: 136)

The well known case of Monica, who George Engel studied for 30 years, born with oesophageal atresia which necessitated feeding with a tube directly into her stomach till she was 21 months, is a case in point. Although Monica never

saw the films made of this, when she was a mother she fed her baby girls as she had been, lying flat on their backs across her knees—as two hands had been necessary to hold the tube for her—there was no attempt to contour her babies to the more comfortable position on her arm. She had fed her dolls this way and it is a matter of record that her own daughter in fact started to feed her own baby in this way, later shifting to a more normal position. Presently Julie is in touch with two mothers who feed their children in this way because of oesophageal disabilities and it will be interesting to observe these and Ailsa as they grow.

Two more examples:-

A child was encased in plaster at nine months for a broken femur which made it difficult to change nappies etc. Later in the play room this child was excessively concerned with 'dirt and smells'. Another child was bandaged and hospitalised at nine months when treated for recurring eczema for some months. The separation from insecurely attached parents was traumatic and he recalled in therapy the feelings of intense sadness associated with cream coloured shadowy walls like hospital corridor walls. In therapy he described alternating impulsive relationships with several women in which need overcame caution, somewhat replicating those with the nurses when in hospital. He was also stuck, immobilised in therapy for some time before a new capable self emerged.

Share (1994) records many instances of adult clients whom analysts have described with dream fragments and behaviours which later exactly parallel recovered memories or corroborated information about their lives. She says "the presence of another who is willing to consider the whole of a person's life and to understand it at its very depth seems to help the patient to 'mentalise' the terrible pain – to bring it to a form in which it can be thought about, and mentally borne. Once it is borne, a turning point seems to occur in the treatment – symptoms are alleviated, and real life begins" (p. 167).

In conclusion, it seems that a secure supported mother-infant attachment may help diminish the effects of shock and strain trauma eventually, while insecure attachment due to inadequate or enmeshed processing may increase the effects with anxiety, inability to self-regulate, and withdrawal. My observation of Ailsa is that the former has occurred. We also feel hopeful for evidence of this in the future.

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