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Maternal Function in Women with Pre-Term Child in Neonatal Unit

Función materna en mujeres con niño pretérmino hospitalizadas en unidad neonatal

Função Materna em Mulheres com Filho Pré-Termo Hospitalizado em Unidade Neonatal

ABSTRACT

Prematurity of birth can interfere in the mother's relationship with her baby, with risks of establishing psychic failures. So, this research sought to analyze how the maternal function can be affected by the conditions of premature birth of the baby and by the therapeutic itinerary in a neonatal referral unit for the Kangaroo Method. 06 mothers of preterm babies participated. Open interviews were conducted, using the conceptual operators of the protocol axes of the Research on Clinical Risk Indicators for Child Development (IRDI) as guides.The study was submitted to the Ethics Committee in resolution 466/12. In content analysis, the following thematic categories emerged: “Repercussions of premature birth in the mother's subjectivity” and “About time and support networks”. It was understood that the waiting time for the hospitalization of the preterm child can work for the mother as a time for psychic re-elaboration. The support networks and transfer attenuared the obstacles established in the mother-infant relationship, thus protecting maternal-infant mental health.

DESCRIPTORS: Pre-Term; Psychoanalysis; Intensive Care Units.

RESUMEN

La prematuridad al nacer puede interferir en la relación de la madre con su bebé, con riegos de establecer fallas psíquicas. Entoces, esta investigación trató de analizar cómo la función materna puede verse afectada por las condiciones del parto prematuro del bebé y por el itinerario terapéutico en una Unidad Neonatal de referencia para el Método Canguro. Participaron 06 madres de bebés prematuros. Se realizaron entrevistas abiertas, utilizando los operadores conceptuales de los ejes del Protocolo de Investigación. Indicadores de Riesgo para el Desarrollo Infantil (IRDI) como guías. El estudio fue presentado al Comité de Ética, de acuerdo con la resolución 466/12. En el análisis de contenido, surgieron las se siguientes categorías: “Repercusiones de la prematuridad en la subjetividad materna” y “Sobre el tiempo y las redes de apoyo”. Fue entendió, que el tiempo de espera para la hospitalización del hijo prematuro, puede funcionar para su madre como un tiempo de relaboración psíquica. Las redes de apoyo y la transferencia alliviaron los obstáculos establecidos en la relación madre-hijo, protegiendo así la salud mental materno-infantil.

DESCRIPTORES: Prematuro; Psicoanálisis; Unidades de Cuidados Intensivos Neonatales.

RESUMO

O nascimento prematuro pode interferir na relação mãe-bebê, com riscos de instaurar falhas psíquicas. Objetivo: Analisar como a função materna pode ser afetada pelas condições do nascimento prematuro do bebê e pelo itinerário terapêutico em unidade neonatal de referência para o Método Canguru. Método: Participaram 06 mães de bebês pré-termos, através de entrevistas abertas, utilizando os operadores conceituais dos Indicadores Clínicos de Risco para o Desenvolvimento Infantil (IRDI) como norteadores. O estudo foi submetido ao Comitê de Ética, de acordo com as Resoluções 466/12 e 510/16. Resultados: Duas categorias temáticas emergiram da Análise de Conteúdo: “Repercussões da prematuridade na subjetividade materna” e “Sobre o tempo e redes de apoio”. O tempo de espera na hospitalização do filho pré-termo repercutiu para a mãe como um tempo de reelaboração psíquica. Conclusão: A rede de apoio e a transferência atenuaram os entraves instaurados na relação mãe-bebê, protegendo a saúde mental materno-infantil.

DESCRITORES: Pré-termo; Psicanálise; Unidades de Terapia Intensiva Neonatal.

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INTRODUCTION

The findings regarding the humanized care of preterm infants had a direct effect on the transformation of Brazilian neonatal units. The traditional biomedical style has become ineffective in promoting health early in life. Interprofessionalism and new care protocols valued the uniqueness of the baby, making the hospital environment more welcoming, although, in some cases, far from ideal. [1]

Regardless of being born prematurely, every human baby is immersed in psychic helplessness at birth. It depends on an adult who performs basic care and meets your needs. However, although totally dependent, the baby is not totally passive. Since intrauterine life, he is competent to interact and capture information from the environment. He is born with a predisposition to contact with the other and with physical particularities that serve as a basis for his psychic constitution. His biological repertoire and his appetite for affection qualify his responses to the external world. He assimilates and interprets experiences with the people around him, being active in the relationships he establishes. [2]

For the baby to come to be constituted as a subject and to structure itself subjectively, it is necessary that someone invests expectations, desires and dreams in and for the same, assuming there is a possibility for the future. This primordial investment psychically organizes the baby, makes a subjective anticipation, positioning him as a subject to come. There needs to be someone who launches into this enterprise of doing a maternal role for the baby. [1,3,4]

One way of observing the establishment of this affective relationship between the baby and its mother is through the four axes that guide the Clinical Risk Indicators for Child Development (IRDI - Indicadores Clínicos de Risco para o Desenvolvimento Infantil): assumption of subject, establishment of demand, alternation of presence-absence and maternal function. [5] They summarize the psychic constitution operations, as they witness the effects of the inscriptions of the marks printed on the baby's body, by the other caregiver. Therefore, public health services have paid attention to these axes, which serve as a scientific methodology for health promotion. [6]

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They are healthy to think about the mother-preterm baby relationship. The arrival of this hospitalized baby has implications for the performance of the maternal function. The mother may experience psychic difficulties that interfere with her identification with her baby, given the demands he places on her. At birth, he is taken from his mother, requiring interprofessional interventions. The mother is overwhelmed by a devastating feeling of guilt, facing her "dying baby". And she may come to compete with the team, which has knowledge about the baby from birth to hospital discharge. Such experiences outline the trauma and urgency of the beginning of life, making it difficult to accept the baby from reality. [1,3,7]

The baby follows an arduous and unstable therapeutic path in the stages of care in the neonatal unit. There comes a time of crisis, through which the baby and family are susceptible to psychic risks. [8] To preserve the maternal function, therefore, the baby's psyche, there must be interventions that allow the baby and the mother to “manufacture” themselves as such. [7]

In the neonatal unit, Psychoanalysis proposes to listen to the babies, but first to make

it easier for the mothers' suffering to be put into words, symbolizing the missed encounter. Psychoanalytic listening is a facilitator, so that the paralysis in the face of vicissitudes in the neonatal unit gives way to the time of understanding, the time of mourning and the time to give new meaning. [1]

Therefore, the aim of this research was to analyze how maternal function can be affected by premature birth and the baby's therapeutic itinerary in a neonatal unit.

METHOD

Mothers of preterm children admitted to a neonatal referral unit participated. Initially, her baby was in the first stage of care, in the Neonatal Intensive Care Unit (NICU) or in the Intermediate Neonatal Conventional Care Unit (UCINCo). The research continued until they went to the Kangaroo Neonatal Intermediate Care Unit (UCINCa), configuring a hospital therapeutic trajectory.

The triggering question of the open and audio-recorded interview was: "What is it like for you to have had a premature birth and have your child hospitalized in a neonatal unit?" In handling the interview, the IRDI was used as a reference to interpret the maternal narratives.

The transcripts of the interviews underwent Thematic Analysis, interpreting the latent content of the speeches and their assigned meanings. [9] And psychoanalytic theory served as an interpretive lens, including the IRDI axes and aspects of a transference nature.

The research was approved by the Ethics Committee under opinion number 2.457.357 and the mothers signed the Informed Consent Term.

RESULTS AND DISCUSSION

The analysis of interviews with 06 mothers, Daisy, Bromeliad, Violet, Tulip, Orchid and Sunflower (fictitious names) generated the following thematic categories: 1) Repercussions of premature birth on the mother's subjectivity; 2) About time and support networks.

1) Repercussions of premature birth on the mother's subjectivity:

About the premature birth of the child, the fragility of his body and his hospitalization, the mothers expressed despair, fear and surprise:

> *“I had no idea that I was going to have a premature child (...) I was desperate.” (Violet);*
> *"Because the water broke, [I felt] very afraid." (Daisy);*
> *“When I saw it, wow, so tiny. (...) I cried, because I didn't expect it to be that way. (...) I thought I wouldn't survive.” (Bromeliad)*

Studies show that some mothers feel confused, filled with guilt and wonder if they could have avoided premature birth. This first impact of seeing the baby in the NICU can be experienced as traumatic and harmful to the formation of bonds. [10,11,12]

For some mothers, such devastating emotional reactions were a rehash of previous losses:

> *“Because I had already lost one, who was stillborn, right, (...) [I felt] very scared [...] of being stillborn again, right.” (Daisy)*

However, the previous story could be at the service of a productive narrative. Tulipa's first preterm child survived: the repetition of prematurity, even though it hurt this woman's narcissism, also strengthened her, like a spark to bet on the new child. The second trauma triggered the previous victory, the first trauma became a remedial resource:[12,13]

> *“It was a little more relaxed, because I already have a girl, who was also premature (...) I already knew a little bit about everything, right, then it was calmer...” (Tulip).*

Tulipa announced knowledge about the lived reality. By assuming knowledge, it proved an indispensable share of “tranquility”, reducing anxieties and fantasies. Interestingly, this baby was suffocating (“crying”, “angry”, “nervous”), transmitting to his mother complaints of a hostile environment. Being a weeper, he addressed an appeal, telling of his difficulty in taking her place, looking for her to protect him from disorganizing external excitements. Again, encouraged by her improved side, she allowed herself to be captivated by the baby's smile, interpreting it, and the preterm was competent to parent her mother, as if she had perfectly understood her message. [13,14,16]

Studies show that babies and their mothers are able to mutually regulate feelings, through their own rhythms, using exchanges of multimodal signals and facial, vocal and gestural imitations, and that even in a context of premature birth, the baby can demonstrate the same desire for protoconversation, through exchanges of facial expressions, vocalizations or gestures with rhythm and investigative perception. In this dialectic, the mother guaranteed the baby's personality; in urgency, she saved his life: [14,16,17,18]

> *“His way, in addition to having a strong temper, he likes me to talk to him, he is very smiling”. (Tulip)*

In this maternal investiture, they located a subjective place for the child, even if his future was perceived as uncertain. He described him as “touchy” and “a little surprise box”, taken by the fear of losing his offspring. Thus, these signifiers humanized babies, and were offered as vital: [1,4,5,6,7]

> *"Thank God, it's alive, right!" (Daisy)*

These were words that surrounded the incubators. Immersed in the constant threat of annihilation, of all sorts, babies were given a possible place in maternal subjectivation. [13] It was detected that they - supposedly subject to come - pointed to the qualifiers that the mothers identified in them. The baby will weave his impressions and build his knowledge from a multimodal capacity to interpret the world and the rela-

tionship with the other. And the psychic organizers - voice, look and touch favored the establishment of the maternal function: [3,4,6,17]

> *"When you start picking up your baby, (...) his recovery is faster (...) She already hears my voice, (...) I see her already (...) listening, looking up, [...] sucking his hands, hungrily." (Orchid)*

Synchrony also appears to be involved in the co-regulation of these affective states; that is, it would be a process where mother and baby, during interactions, combine the affective states of each other, as in a duet, where mother and child are getting in tune from each exchange experience. [16,17,18]

In this way, they spoke of their maternal desire, impacted by the horror of prematurity and as Other Primordial, they anticipated an existence for the baby, inscribing the first subjective marks on their bodies, bathing them in language. And in the formation of their psychic rearrangements, feeling that they are an important part of their child's recovery, waiting for the time to take him home; the role of the support network was remarkable.

2) About Weather and Support Networks

Preterm hospitalization time is a period of crisis, [8] with effect on the subjectivity of mothers. It took a chronological time, but also a subjective time, for their psychic rearrangements in the face of the trauma of prematurity. [3] Prematurely mothers, they needed time to manage their affective relationship with the reality baby. Due to their unique style, they supported the lack imposed by the reality of the baby's hospitalization. The time lived in the hospital was given new meaning, as they absorbed a kind of necessary learning. After that, they felt able to mother their child, even insecure in the face of the cruelty of the baby's temporal experience of hospitalization:

> *"The routine of having [...] a day of glory, of victories and another day not, it won't always happen what we want". (Bromeliad)*

Little by little, they experienced an acceptance and improvement of themselves:

> *"I don't know if it's because of time, (...) I started to accept (...) that it had to be like this [...] It's maturity." (Sunflower)*

His flagellated organic body is not normalized in the chronological temporality of the parents. And the danger is established in the imperative of haste.

The hospitalized preterm baby is out of time. His flagellated organic body is not normalized in the chronological temporality of the parents. And the danger is established in the imperative of haste. Emotionally disorganized mothers can fix the imperative of the accusation, naming them late, complainers of the weak body, which does not respond to medical procedures, in the same rhythm of the time of reality that vanishes. [3,10] Sensitive to a time that is not hers, Orchid did not suffer in that time, she accepted the baby's neurophysiological variability. Singled out, he no longer just had to produce in the time expected of him: he faced the maternal demand (gain weight, breastfeed, breathe without devices), but he met a mother who was attentive to his needs, calling him to overcome the lack of organic differentiation [14]:

> *"I'm learning to be patient, because the time is not mine (...), I have to learn to wait for her time." (Orchid)*

In order for the mother to be able to invest in this child, weakened by the prematurity of its arrival, it is essential to work on the mourning, loss and separation of the idealized child. This is an interventional possibility for the mother to be able to project for her preterm baby a possible future, a living project. In this sense, the length of hospital stay may allow the mother to work to repair her own image, authorizing her to become a mother to her child. [3,7,10] The exercise of the maternal function was also facilitated by the fact that they felt supported by the health team, along the baby's therapeutic itinerary from the NICU/UCINCo to UCINCa [19,20]:

> *"(The nurses) are always advising you like this, calming you down." (Orchid). "Thank God, all the residents, the doctors who are with him, (...) [they are] always supporting me, always supporting him." (Sunflower)*

This support network extended to her bond with other mothers in the unit, nurturing feelings of self-confidence, personal fulfillment and dedication to the baby: [10,11,15,19,20]

> *"From what we go through here, (...) we need comfort, there are (mothers) who are closer to you and give a word of comfort. As I can also give, it helps." (Bromeliad)*

Health professionals and other mothers assumed the role of the third continent. [11,20] They mediated and contextualized the mother-infant relationship, protecting each other from their deadly fantasies.1 When they felt cared for as women-mothers, they spoke of comfort, help, advice and support for themselves; noticed the

humanized care for the baby; without them noticing, they were also crossed by the organizing transfers:

> *"I feel (...) safe in relation to the care they are giving and he" (Violet); "Here (...) is the hospital that (...) premature babies have a chance of surviving, (...) because it is a suitable hospital." (Orchid)*

The redefinition of the time lived, the mediating function of the support network and the transference relationship with the unit helped these women to repair their own image, empowering themselves as a mother to their child.[3,7,11,14,20]

CONCLUSION

When analyzing how the maternal function was established in the neonatal unit, it was noted the manifestation of maternal desire challenging the incubator. Even with the fear of losing their child, upon realizing the real fragility of the prematurely born body, mothers anticipated their babies, giving them a subjective place. The length of stay and the support of the hospital support network (professionals and other mothers) generated something creative: the mothers allowed themselves to have unconscious knowledge about their child. Although reality will be guided by risk factors to their mental health, these factors provided opportunities for their psychic re-elaboration. Counterbalanced with the risks, the transfers conceived protective factors for maternal and child mental health. So, it is up to the psychoanalyst to listen to these women and read the bodily productions of their babies, facilitating the elaboration of the trauma and recognizing their maternal potential. However, it is necessary that the health team is involved in the care relationship, supporting this mother, so that a path for promoting maternal health and psychological prevention for the baby, who is in a state of prevention, can be traced. ■

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