SciForschen
Open HUB for Scientific Research

Journal of Psychiatry and Mental Health
ISSN 2474-7769 | Open Access

REVIEW ARTICLE

Volume 9 - Issue 1

A Therapeutic Tool in Institutions: Observing the Baby using the Esther Bick Method in Neonatology

Camara Momar[1]*, Seck Sokhna[2], BA El Hadji Makhtar[3], Ba Idrissa[4], Wade-Kane Racky[5], and Sandri Rosella[6]

[1]Department of Psychiatry and Medical Psychology, Cheikh Anta Diop University, Thiaroye National Psychiatric Hospital Center, Dakar, Senegal
[2]Department of Psychiatry and Medical Psychology, Cheikh Anta Diop University, Moussa Diop Psychiatric Clinic, Fann National University Hospital Center, Dakar, Senegal
[3]Department of Psychiatry and Medical Psychology, Cheikh Anta Diop University, Albert Royer Children's Hospital, Dakar, Senegal
[4]Department of Psychiatry and Medical Psychology, Cheikh Anta Diop University, Moussa Diop Psychiatric Clinic, Fann National University Hospital Center, Dakar, Senegal
[5]Department of Psychiatry and Medical Psychology, Cheikh Anta Diop University, Moussa Diop Psychiatric Clinic, Fann National University Hospital Center, Dakar, Senegal
[6]AIDOBB (Association internationale pour le développement de l'observation du bébéselon E. Bick)

***Corresponding author:** Camara Momar, Department of Psychiatry and Medical Psychology, Cheikh Anta Diop University, Thiaroye National Psychiatric Hospital Center, Dakar, Senegal, E mail: momarcamara@yahoo.fr

Received: 29 Jan, 2024 | **Accepted:** 17 Feb, 2024 | **Published:** 24 Feb, 2024

Citation: Momar C, Sokhna S, El Hadji Makhtar B, Idrissa B, Racky WK, et al (2024) A Therapeutic Tool in Institutions: Observing the Baby using the Esther Bick Method in Neonatology. J Psychiatry Ment Health 9(1): dx.doi.org/10.16966/2474-7769.155

Abstract

The authors participated in observing a neonatology unit of a children's hospital in Dakar, which had the only respiratory assistance device in Senegal. This study aimed to show that observation of the baby using the Esther Bick method was effective in the early intervention of psychopathological disorders in the mother-child relationship.

This observation, an institutional application of Esther Bick's observation method, allowed the authors to experiment with this technique for the first time. The results revealed the early interactions of a baby in a family where suffering related to the context of out-of-wedlock birth was unfolding, which had led to the social exclusion of the mother. The mother's transgression was socially interpreted as the cause of her baby's illness. Thus, through the sessions, the observation enabled a re-enactment of a social issue that was expressed within the hospital institution.

We believe this observation may have had an essential containing function for the baby and his family and opened avenues for reflection on early interventions addressing the baby and his family.

Keywords: Observation using Esther Bick's method; Pediatrics; Human-machine relationship; Dakar

Introduction

There is no such thing as a baby is one of the lessons we can draw from Winnicott [1]. Long considered to be a thinking being, the baby has long jealously guarded its secret universe. Freud's work on psychosexual development theories [2] was the first to offer hypotheses for understanding the baby. Other authors contributed to the development of baby psychology, namely Watson [3], Piaget [4], and Bowlby [5]. In his Tavistock clinic; the latter collaborated with a Polish psychologist, Esther Bick, to develop an original technique for observing the baby in its family [3]. Thus, in its classic form, the observation occurs in the family every week for two years. It lasts one hour, followed by a time of writing and a time of presentation at the seminar under the direction of a trainer (9) [3]. It was intended for the training of psychoanalysts. Its manifest interest in supporting the baby's development contributed to its expansion into other early childhood sectors: daycare, orphanage, and pediatrics.

Its introduction into the pediatric environment is justified for several reasons. As applied in neonatology, observing infants using Esther Bick's method occurs in a particular situation. Indeed, we are confronted with a baby in the care of caregivers who have to deal with being unable to express its suffering and parents who have difficulty exercising parenting in a setting where it is relatively challenging. In emergencies, there is the additional fear of losing the baby at any time.

Golse [5] considered observation in a neonatal setting as a complementary approach to semiology. It offered a psychopathological reading that did not verify what we already knew but where we put ourselves in a position of receptivity to the unexpected. Houzel [6]

formulated the goal of containing the parents' suffering, requalifying them, sorting out confusions between generations, allowing identification with the observing function, and serving as a transitional phenomenon, allowing the therapist to acquire a familiar character.

To propose a complementary approach to pediatric care, we conducted a series of observations in a neonatology unit in a children's hospital in Dakar. These observations were applications of Esther Bick's infant observation method. We thus conducted three observations of a newborn selected by the neonatology team. This work highlighted early mechanisms of newborn interaction in an institutional context.

The development of baby observation in Senegal

The technique of baby observation was introduced in Senegal in 2008 by Mrs Rosella Sandri, a Belgian psychoanalyst of Italian origin [7]. It was a bilateral Belgian-Senegalese project with the Belgian partner, the Wallonia-Brussels delegation. After years of training for mental health and early childhood professionals, the project has expanded. Indeed, the collaboration with Cheikh Anta Diop University in Dakar has allowed the opening of a University Diploma entitled "Baby Observation and its Clinical Applications". The extension of the project has also made it possible to intervene in pediatrics in partnership with neonatology services in Dakar hospitals.

Observations

Meeting with the care team, the baby (4 days old), and the aunt.

This moment represented my first contact with the baby's family. After introductions by the care team, we headed to the large room. The aunt adeptly put on the gown. I did the same, and we entered the room together. The aunt started talking to me. She explained that she came to the unit every day and that the mother was sick and too weak to visit the baby. She told me about the difficult birth context of the baby who was born out of wedlock, which meant that she found herself alone in caring for him and supporting the mother, whom the family rejected. She had also been the one to take her sister to the hospital when labour started, which had brought criticism for transgressing customs, and this was also seen as contributing to the baby's condition. She absolved herself, saying she had to do it given the baby's imminent arrival.

The aunt told me about the problematic delivery conditions with the baby in distress, having swallowed amniotic fluid. He had not cried but did so much later, emitting a faint cry, undoubtedly due to a triggering effect from the other newborns in the room. He had been kept for a long time, and it was only upon the mother's insistent request that he was presented to her. He seemed lethargic, with a flaccid arm that drooped back down after elevation. The next day, when she came for discharge, the team proposed a transfer to this facility for respiratory assistance. The worried mother wanted to know her baby's health status; that was when she learned he had an infection and neurological impairment. The aunt asked me about the baby's condition - he never moved, unlike the other babies, pointing her finger at them, those other babies who also occasionally opened their eyes. This worry continued when she shared her distress about the morning phone call, and despite the doctor's explanations, she thought it was to announce bad news. She burst into tears, demonstrating the difficult position she was in. Her sister was being criticized, and in reaction, she had fits and screamed. This was despite her insistence that her sister be treated kindly. She called on friends to keep her sister company in her absence. She took a piece of her veil to wipe away the tears that kept flowing.

The aunt was indignant that no family member visited the baby or asked about him.

There was an inscription on the baby's temple with the name Aminata Sy and a date of 4/4/2017. I addressed the baby and said: "Aminata, excuse me for not greeting you earlier; how are you?"

She corrected me by saying that it wasn't his name; the baby was a boy, and since he was only born on Sunday, he had not been baptised yet and, therefore, had no name. But he was registered as "baby of Astou Sall" on the part of the crib, she pointed out. I made another mistake, apologizing and then saying hello, this time to baby Astou before she explained again that was the mother's name and he had not yet been given a name. I had misunderstood the first correction.

She received a phone call from someone she reassured, then promised to call back. She then told me it was the mother and that this always happened during her visits; "She is compassionate and attached to her baby; she always plans to accompany me on the visit but changes her mind at the last minute on the pretext of health problems".

She returned to her pain and also the behaviour of their father, who was uninterested in the situation and even threatened to expel her sister from the house, so much so they had been dishonoured. She also said she did not receive information on the baby's condition, but especially that she was ready to exchange her life to save him if he did not survive. Silence then set in, which allowed me to look at the baby again, still plunged into his sleep and looking peaceful and calm. The machines continued to be heard, and she drew my attention to them, mainly the large one: "Is it serious when you hear it?" I referred her back to the care team.

I decided to announce my departure to the aunt after 35 minutes. I did the same with the baby. The aunt stopped me to ask if we could talk to him.

Meeting with the Mother, Aunt, and Mady (2 weeks and 2 days old)

There were two chairs at the baby's bedside; the mother sat on the one to the right and the aunt on the other after wanting to give me the place. The baby had grown over the past two weeks; he now had body hair. However, he had a large bump on his head, about 10 cm in diameter, in the parietal region towards the middle; I linked it with a hematoma due to an IV. His right hand also showed a similar type of hematoma. His head seemed more significant than on the first day, making me think of hydrocephalus. His face was more mature; he had a tube in his nostrils. However, the respiratory assistance had been removed. He still maintained the same position but was less open in attitude. The surroundings had also changed; at least one of the four babies was new.

The mother, in tears, asked me for my diagnosis as a psychiatrist. I clarified that I was there for training but not as a psychiatrist or to make a diagnosis. She complained of being neglected and not receiving enough information about her baby, especially since she was the one who had raised the alert about her baby after birth. "I noticed he was not sleeping, feeding or crying, unlike the other babies. They took my baby and separated us for 3 hours, and I had to get angry for them to give him to me for feeding. I have been spoken to rudely; it's not dignified for care staff".

She linked the problems to what was admittedly a difficult delivery due to prolonged labour but also an injury inflicted during delivery.

I asked her what information she would like to have. She wondered if her child was okay and if he would have any problems later on. However, she changed her mind and said not all staff were like that, and some did listen to her. Still crying, she asked me why she could not

breastfeed her baby like the other mothers. She let me know she would be happy to express milk, pointing to the two small feeding bottles by the baby's bed while not being sure, according to her, that the milk was even given to him and that he had to be fed by syringe, pointing to the tip of the feeding tube connection. She got up for a moment and stroked both her baby's arms. Despite this, I did not feel any closeness between the two. She then stood for a while before asking permission to withdraw; we had been in the room for about fifteen minutes.

The aunt asked me to understand her state, which was difficult to live with. She revisited the concerns about the fate of the bump and then the right hand. I referred her back to the care team; she told me she did not understand the answers - was it because of the terminology? No, she told me, it was "because I am in a state of confusion that does not allow me to".

She then talked to me about hematomas due to the circumstances of delivery. I looked at the baby again and then asked his name. Baby Mady, she told me, was the name of their younger brother. She also said the baby was doing fine, the infection was gone, and he responded better. She seemed concerned about her sister, who was outside. Indeed, she kept glancing towards the exit several times.

We joined the mother outside. She got up and came towards us. She violently posed the same questions about the future of the baby's symptoms. She then turned around in sobs and headed for the exit. Her sister and I followed her.

The aunt was unavailable a week later while confirming the mother's presence. Indeed, the baby had left the emergency room for the one next door, revealing a good evolution of his health.

Third Observation of Mady (3 weeks and 2 days old)

"Good morning, Dr. Camara," this was the warm welcome I received from Nogaye.

I was surprised by this friendly and cheerful face, which contrasted with the behaviour observed during the previous observation. She picked up Mady, put him on her lap and started feeding him. Baby Mady was also calm, eyes open. His right shoulder was strapped (bandaged). I told her that her baby was lovely. She smiled and told me his mom had thought the opposite when she came by. I then thought that the tension must have eased in the family. I asked about her sister, and she told me she had gone to her school.

Nogaye started the meal by administering a syringe full of milk from a bottle. She inserted the syringe and gently pushed it inside Mady's mouth. Her movement was cautious and delicate. Mady sank into a semi-sleep and seemed to have trouble opening his eyes. He stared for a while with his eyes open but rolled back. However, he seemed almost indifferent, perhaps too calm and not very reactive. I also found him a little mature in this attitude. The parietal bump was gone, and he seemed to regain the appearance of a "normal" baby.

He finished the first dose, and Nogaye refilled the syringe. She removed the tip of the syringe from the feeding tube nozzle. Some milk escaped from this end, but it did not bother Nogaye, who recharged the syringe she reattached to the tube. She reintroduced the tip into Mady's mouth. However, he rejected the syringe and accompanied this movement with his left hand. Nogaye was undeterred and reintroduced the syringe into his mouth.

Mady struggled to calm down. Nogaye stopped feeding, separated the syringe from the tube, and then increased the rocking pace of her knees, giving her the momentum to rock her baby. She changed his position and took him to her chest when he did not calm down. She shook him rhythmically with her hands, speaking to him: "Calm down, my baby."

Given his persistent crying, she put him on the bed and checked his diaper. That was when she realised he had "pooped." She removed the diaper and grabbed three wipes. It made me think of her lack of experience and that there was perhaps some apprehension about the baby's stool. The way she cleaned confirmed my hypothesis. Indeed, she wiped his butt, then grabbed more wipes, then more to finish. She had lifted both feet for better access to the buttocks. She then took another diaper that she placed next to Mady, but it took a long time to put it on the baby. Mady took the opportunity to pee, and it was only after that she realised it and started to feel overwhelmed. Mady had indeed wetted part of the bed. Nogaye put the diaper on him and then remained motionless for a while. She then offered that I hold him while she changed the bed sheet.

For the first time, I came into very close contact with Mady. He was awake and held his gaze towards me. He had stopped crying and calmed down. At times, I felt him startle slightly; it made me think of the convulsions the paediatricians had mentioned.

I held him at chest level, rocking him gently, at times whistling to accompany his slight movements. Nogaye took the opportunity to make the bed and tidy up the clothes. Mady burped and then regurgitated some milk at the same time. I drew Nogaye's attention to this - she was a little dismayed: "And I had just done the laundry..."

At the same time, Mady finished defecating with a big sigh. Which further discouraged Nogaye when I handed him back?

Discussion

What is striking during the first observation is the violence of the context in which this baby was born: he is a baby born from an unsupported pregnancy, rejected by the young mother's family, who found himself in great distress following the family's rejection. We are struck on the one hand by the mother's screams and fits and on the other hand by the fact that the baby could not even cry, as if in these extreme manifestations, there was, on the one hand, too much pain (from the mother) and the other hand unspeakable suffering from the baby. We feel that for both, there was no maternal containment.

The second striking aspect of the first observation concerns the baby's name and gender. On two occasions, the observer addresses him, calling him by a first name that is not his... this shows, in our opinion, his need to recognize the baby, to give him a name he has not yet received. We believe this moment is critical because it represents a moment of the observer's recognition of the baby as a person.

Third, we feel that this recognition by the observer allows the aunt to express her attachment to the baby during this observation. She declares love well by saying, "She was ready to exchange her life to save him". We believe that her role has been vital for the mother and the baby because she has ensured that a life-giving link is maintained for the baby and between the baby and his mother. We also feel that she has been able to promote the bond between mother and baby by leaving room for the mother when she could be present.

These thoughts lead us to connect with the second observation, in which we can discover the baby's mother. The aunt's hesitation over which chair to take shows her need to "give up her place" and not take up "too much space" when the mom is there. During the second observation, we meet a mother who expresses not only great distress but also a great need to understand what is happening to her baby and to be heard in her good maternal intuitions. She affirms her ability

to perceive signs of her baby's suffering ("did not sleep or feed or cry either") and, at the same time, she need not be separated from him for too long ("they separated us for 3 hours and I had to get angry for them to give him to me for feeding").

We see that the observer's presence played a very important role for the mother because the observer's attentive and respectful listening allowed her to express her distress and affirm her attachment to her baby.

Indeed, the observer is in this receptacle position where he receives the different projections from the actors surrounding the baby. The observer thus made it possible to shift the maternal projections so that they do not reach the baby [8], allowing the mother to get closer to her baby as well.

The observation allowed the different actors, including the baby, to externalize their difficulties' with the cultural environment. Thus, the aunt expressed feelings of guilt related to complicity in the mother's transgression and guilt of extra-marital relationships followed by pregnancy. She then had to ensure both the safety of the baby and that of the mother at the same time.

The mother was steeped in feelings of anger, distress and helplessness. Both had exhibited confusion that made them unable to hear the caregivers' discourse. This confusion had also reached us, testifying to the identification games in which the observer could take part.

However, we note that during the observation, the mother's perception of the care staff becomes more nuanced when she says, "It was not all staff who did not listen to her".

The mother seems to have a lot of doubts about her maternal abilities (she is not sure her milk is given to the baby), and when she strokes both arms of the baby, the observer does not feel a real closeness.

We finally discover the baby's name at the end of this second observation!

During the third observation, the observer is also named ("Good morning, Dr Camara!"), and for his part, he discovers the mother with a sympathetic and cheerful face and tells the mother that her baby is lovely!

Elisabeth Chaillou [9] emphasized the role of observation, which allowed the mother to talk about her abilities as a mother. This state had been noticed post-maternal crisis where one could see the delicacy of her gestures and, in the end, the question of the observation feedback. ("What did you find?")

Finally, the baby had also taken part in this crisis, albeit delayed. This manifested itself through emotional escalation, where externalization occurred through bodily orifices.

Implications

This first successful observation experience in a neonatology unit offers a lot of potential for achieving optimal care for young children. The first experiments carried out in neonatology departments have convinced pediatricians of the value of this technique. Thus, many readjustments have been made by these teams to consider the specificities of the child's development. The long-term goal will be to extend the technique throughout the country by providing training to pediatric teams [10].

Conclusion

Throughout these three observations, we can witness the development of a psychic and relational history in which the function of observation has been very important for the mother, the baby and the unit that welcomed them. We can say that, gradually, a containing function has been able to develop: on the mother's side, we have seen that being able to "evacuate" her anxieties "into" the observer allowed her to come into contact with more containing parts of herself for her baby. On the baby's side, we see, during the last observation, that he also evacuates, with his urine and stool, emotional experiences that the mother can "clean up". Admittedly, the observer perceives all the inexperience of this young mother and her "overflow", but at the same time, he also sees that she can ask the observer for help. Indeed, she asks him to hold the baby while she remakes his bed, allowing the observer and baby to have this touching contact through gaze, touch, rocking, sounds and whistles ... We feel this is a very soothing moment for both baby and mother, even if she seems a little discouraged by the fact that she had just done the laundry that the baby dirtied again! But the baby's sigh at the end of this sequence seems to underline that there has been a relief and that he has been able to free himself from psychically and physically cumbersome contents.

In conclusion, we believe that the unit that welcomed the observer has also benefited from his presence and has been better able to fulfill its containing function towards the baby and the mother.

References

1. Winnicott DW (1958) The capacity to be alone. In: DW Winnicott (ed.) Through paediatrics to psycho-analysis. The Hogarth Press and the Institute of Psycho-Analysis, London 29-36.
2. Freud S (1987) Three essays on the theory of sexuality (French ed.). Paris: Gallimard. (Original work published 1905).
3. Watson JB, Rayner R (1920) Conditioned emotional reactions. J Exp Psychol 3: 1-14.
4. Piaget J (1952) The origins of intelligence in children. W W Norton & Co.
5. Golse B (2013) From Primary Symbolization to Secondary Symbolization. A Plea for a Continuous Spatio-Temporal Gradient around the Notion of Gap. Cah de Psychol Clin 40: 151-164.
6. Houzel D (2011) Observation of the baby in early intervention. Contraste 34-35: 237-253.
7. Ba I, Sandri R (2009-2010) Training in observation according to E. Bick. Establishment of a group in Senegal, perspective. Psychopathologie africaine, 35: 259-278.
8. Waddell M (2006) Infant observation in Britain: the Tavistock approach. Int J Psychoanal 87: 1103-1120.
9. Chaillou E (2014) Observation of a Premature Baby in Neonatology According to the Esther Bick Method. In: Dugnat M (ed.) The Art of Accommodating Embryos, Fetuses and Babies. ERES "Childhood & Parenthood", Toulouse 201-212.
10. Scoury D (2016) The Contribution of Training in the Esther Bick Method to the Work of the Bond Between Mother and Baby. Perspect Psy 55: 121-128.