them, such as Britain, Spain, and Belgium. On the other hand, due to a long waiting list, thousands of British couples who require donated eggs now travel to Spain, Cyprus, and Eastern Europe. Rules on the maximum number of embryos that can be transferred to a woman's womb also differ widely, despite the scientific consensus that the safest policy is to limit implants. In Britain, Scandinavia, and the Low Countries, only one or two embryos may be used, to prevent multiple births—by far the biggest hazard of IVF treatment. Germany and Italy insist that every embryo created is implanted, increasing that risk. Similarly, in the US, where there is no restriction on allocation of sperm, "tribes" of fifty or more half-siblings have found each other through the internet, identified by the donor registration number.

CHAPTER SIX

Overcoming obstacles

Lisa Miller

The foregoing chapters have been about difficulties—serious difficulties—which some parents encounter in the lives of their babies. I should like to put this in perspective by doing two things: by thinking about the ways in which life puts obstacles in the way of everyone, and about how we overcome these obstacles; and also by considering how psychoanalytically informed intervention can help these natural processes to progress and develop. For while it is helpful to think about precise difficulties and the problems they bring, it is also helpful to remember that we can locate them in a wider spectrum, too—the spectrum of experience common to us all. As a young mother who had given birth unexpectedly to a Down syndrome baby said, when confronted by what she felt was too much professional advice: "I thought I'd just like to get to know my baby in the ordinary way first". This chapter is about overcoming obstacles in the ordinary way, remembering that this process is part of everyone's life, that no life is without difficulty and that few are without tragedy.

It is hard to remember that we are born to the human condition. No matter how much we want our babies to be happy and to enjoy life, the fact is that from the beginning life is a mixed affair, and pain

is present as much as pleasure. The question for parents, even in the best circumstances, is how to foster in their children delight in good experiences, and also strength to tolerate and live through bad ones. What helps children to develop their capacity to put up with difficulty, to live through it and to learn from the sense of having overcome it? And how does this start from earliest infancy?

First, it may be important to remember that babies and children have a long period of dependency. They don't struggle to their feet and run with the herd like little deer. They need complete looking after for weeks and months, even years, and only gradually as time passes do they become able to look after themselves. This is true not only physically but also mentally. They are not able to comprehend and manage their own experiences for years to come. Infants need the accompaniment of psychologically mature minds to enable them to think about what's happening to them. Two categories of things happen: events take place inside them, both in their bodies and in their minds, and events take place outside them in the dimension of external reality. These two categories, inner and outer, impinge upon each other and influence each other in a constant system of mutual interaction; and the whole experience of getting to know these worlds needs to be presided over by adults who are reasonably benign and stable. A baby is born relationship-seeking, and within the setting of helpful human relations can grow into a person able to develop optimism and perseverance and to tackle obstacles which involve bearing anxiety and trouble.

This is how the ordinary baby grows up. It may help to trace the process back to the moment of birth. Being born is a taxing process in itself, hard work for the mother and hard work for the baby, and some babies need to recoup as from trauma and exhaustion, their powers of endurance already tested. But even for the baby who arrives bright-eyed and calm, a great change has occurred. From being entirely dependent on someone else's system, plugged in to its mother, living her life with her, the infant has to face a challenge. He or she has to make an independent step and take a breath. This is the very first move towards a separate life. But though literally vital for survival, it is only one step. For everything else, the baby is dependent on other people.

The essential bodily needs of this helpless creature are as follows: to be fed, to be cleaned up, and to be protected. There is no way in which a baby can live without someone to feed it, someone to mop up after it, and someone to mind it. This is obvious. Perhaps it is not so obvious

that for all three of these basic physical needs there is a psychological concomitant, and that the psychological needs are equally important.

First, there is feeding. Children need good food to grow and to thrive, and also to build up strength and resistance. A malnourished child is vulnerable to infections, illnesses, all the accidents which can happen to a small organism. The baby needs to take in milk which is to be digested and transformed into a strong body. But as good food builds the body, so good experience builds the mind. We can imagine ourselves as having a psychological alimentary canal, a system of the mind which absorbs and assimilates what happens to us and makes us what we are. Too much poor and inadequate food will have a weakening effect, and something similar can happen when the baby's emotional needs are not adequately met. Infants take in more than milk at every feed. They take in affection, they take in the sense of someone who wants to look after them, they take in the idea of a trustworthy person, a person who is interested in them, a person who thinks that they are lovely. One could elaborate this list of good experiences which are absorbed and made part of the child's inner world of memory and imagination, of thought, both conscious and unconscious. These good things are stored away and function as a reserve to draw upon when difficulty, pain, and danger threaten.

There are other ways, too, in which the infant is strengthened. I have said that keeping the baby clean is another vital factor in bodily care, and we know that dirty and unhygienic circumstances carry risks. But the level of care that we take for granted means work—changing nappies, mopping up, bathing, clean clothes. And just as vital is the psychological concomitant. Babies require a great deal of attention to their distress. They are born intelligent but uninformed. The process of learning about the world—both the world out here of other people and outside happenings, and the inner world of their physical and emotional sensations—is one which causes extreme pleasure and extreme pain. Infants easily get panicky and bewildered; they are at the mercy of every bodily twinge and every mental doubt. Their feelings are broadcast immediately in the form of cries for help. They need an adult who can receive these messages and be affected by them—can feel some of the distress and primitive infantile anxiety—but who will not be totally overcome. In fact, a sort of mental soaking-up of distress has to occur.

Babies who sense that their distress is noticed and received feel understood and known. Not all distress can be removed. Neither

colicky pains nor panics can always be instantly relieved. But the baby who feels that the adult in charge really takes in some of his or her unhappiness and tries to think what is the matter and to see if it can be made better is a baby who has a chance to take in another kind of good experience—the experience of having someone who sticks to them despite pain and anxiety and doesn't let them down. Sometimes the best we can do for someone else is to keep them company in their distress. The ordinary infant assimilates the idea of someone who does not leave them alone with the problem, but steadfastly puts up with the worry and discomfort involved; this gives the child the opportunity to absorb strength and determination and builds on his or her natural resources and capacity to bear anxiety. Being aware of having faced a difficulty and found this possible is in itself a strengthening experience.

The last physical necessity for an infant is for protection, and this is of various kinds. Keeping a baby safe and warm, holding it when it is upset, defending it from frightening noises and sensations, looking out for dangers—all these are included in the process of looking after somebody who cannot yet look after himself. The overarching function which a parent or carer provides is that of keeping the baby in mind. A new baby needs a person who is preoccupied with him or her, in whose mind he or she lives, someone in a position to give space to the baby in their thoughts; and time, of their adult life, to the child. The absolute need for this diminishes as the baby becomes able to think about him or herself, but as we see from the sad cases of children who have been seriously neglected in inadequate orphanages, the child who has not been thought about cannot learn to think. Multiple indiscriminate caretaking is a disaster. The baby who is not held in mind and remembered is emotionally at risk just as surely as the baby who is not properly cared for in body is at physical risk. A young human being needs at least one person who can bear to have the narrative of the baby's life in their mind, even if the story is a painful one. Babies need, first of all, someone to think for them, then someone to think with them, before they are able to start thinking about themselves.

All this is to demonstrate how babies develop resilience when they grow within the setting of mutual relationships. They bring the capacity for experiencing mutual joy and affection; they bring primitive infantile anxiety stirred up by their vulnerable state. However, parents bring something to the relationship too. They bring their total experience of life to date, everything which has equipped them to be ordinary

good parents, and everything which gets in the way of their natural wish to look after their baby well. The previous chapters of this book have been describing situations where there are obvious difficulties, but all babyhoods encounter obstacles to the baby's innate push towards healthy growth and the parents' wish to facilitate this. I shall describe a situation where an observer visiting a family once-weekly saw a situation where difficulties were overcome in an encouraging way over the period of the little boy's first year.

Edmund

Edmund was born following a number of miscarriages, and his early weeks and months were surrounded by an atmosphere of anxiety and discomfort. There had been difficulties in the pregnancy and Edmund was born a little early. Despite this he was a good weight and sucked well; he seemed disposed to tackle life with some optimism. However, by the time he was five weeks old the observer spent an hour with him and his mother which was hardly free at all from miserable unhappy grizzling from the baby, as though he could not make himself comfortable at all. His mother said that he had been like this all week. She walked around cradling him and trying to soothe him, but although Edmund settled briefly as he listened to her voice, it only lasted a short moment before he began another of the intermittent bouts of crying where he scrunched up his whole body, flexed his arms and legs, and belted out his wails. The observer heard a long account of what the mother called constipation in Edmund, but she (the observer) felt a little puzzled, partly because she happened to know that constipation is rare in breast-fed babies, and partly because it did not sound like what she understood as constipation. Edmund's mother said he sometimes only slept for ten minutes after a feed because of this "constipation"; he'd been "a nightmare", she said. However, after nearly an hour, during which the observer felt considerable unease, the baby eventually settled to the breast, and there followed several minutes of blessed silence with both mother and observer becoming entranced by Edmund's rhythmic sucking and his gradual increasingly floppy relaxation.

Here we see a nursing pair who are both anxious. Edmund has a problem in settling in to this world; this made the observer think about the problems the parents had encountered in establishing a pregnancy that would last, one that would bed down and get going. The mother

is feeling worried on all three of the fronts I called the basic needs of the baby. The feeding is troubling her—it takes nearly an hour to get Edmund going—and she is bothered because he had latched on so wonderfully well to start with; "he was a natural". Perhaps, she thinks, it's to do with his bottom end and this constipation? She understands the problem in terms of his not being able to deal with states of discomfort. We might think that his distress is hard for her to take in and bear—a problem with the second basic need of mopping up both the dirty nappy and the unhappiness. As for the need for Edmund to be held in mind, there is no doubt but that his mother is totally preoccupied with him, but at the moment he does not seem to be occupying a comfortable place in her mind at all. He's a bit of a nightmare. It looks as though Edmund's discomfort is being added to by his mother's discomfort. In addition to whatever's going on inside him (anxious feelings of not being gathered up and relieved, uncomfortable bodily sensations from his chaotic bowel) the poor boy now has the added problem of a mother who is as worried as he is and perhaps more so. She must be concerned that having at last succeeded in bringing a baby nearly to term and giving birth to a lusty suckling she is somehow going to fail again.

At this time, and for some time after, it is noticeable that Edmund's father never appears when the observer is there. She is perplexed by this, as he is occasionally present in the house but in another room, as was the case in the observation referred to above. Mother feels on her own with the anxiety, which continues to affect the observer. There seems an uncomfortable sense of misunderstanding between mother and baby, with her pulling him off the breast just as he is falling asleep and bouncing him up and down in a jerky way, saying "You love this, don't you?" during an observation a few weeks later. The observer thought the baby wore a look of weary resignation rather than of enjoyment. On another occasion Edmund was rocked quite fast and bumpily in his musical chair, and the observer actually began to feel a bit seasick. At the same time mother was saying that she felt her own confidence had deserted her. She had consulted her health visitor and her doctor.

This ushers in a time when mother is much more tired, less bright and breezy, more half-depressed. Simultaneously, Edmund seems by four and five months old to be more awake, less miserable, only crying when his mother's interest lapses. After a feed, on one occasion, she stands him up on her lap. The observer says he looks "as pleased as Punch", smiling over at her and looking as if he really has taken in

something nourishing. Mother is in touch with her own mood, rather exhausted, a bit low, but taking much more interest in what Edmund is actually doing and far less prone to fill the room with anxiety. His development is beginning to reassure her.

Edmund's mother is planning to return to part-time work when the baby is about ten months old. This coincides with a marked shift in the family. In preparation for the change, father plans to work a little less and to share the care of the baby. Father now appears in the observations. The parents give the strong impression of a couple who have found their relationship again. They have discussed plans and worked them out. Reorganisation of the house is taking place, and Edmund has really cheered up. When the observer visits as Edmund turns nine months old, he beams as she enters. Both parents are there; they watch and laugh as Edmund plays dexterously with an old mobile phone. His skills are suddenly developing fast; he plays peekaboo, he swigs from his own bottle of water, he plays a posting game with his mother, and likes to look up at the watching pair—mother and observer—just as he very much likes looking at his mother and father together.

The partnership between the parents is re-established. Obstacles have been overcome as both the nursing couple and the parental couple have linked up. Anxieties which came between them are no longer troubling, and we see, from now on, a much more ordinary course of development, with Edmund particularly relishing his relationship with his father. A space has opened between him and his mother, a distinction has been made between what he is feeling and what she is feeling, and Edmund is much more himself. He recaptures some of the original sturdiness he was said to have been born with.

Pauline

I should like now to turn to a nursing couple who needed help from an external source to overcome the difficulty they were in. Here is a case of a young mother who also brought unsolved problems of her own to the task of bringing up her baby. It is a case I saw many years ago at a GP practice, one which made an impact on me at the time and which taught me some useful things about psychoanalytically oriented interventions with families where the problem appears to be located in the baby, a baby whom I shall call Pauline. The health visitor at the practice asked me to see Pauline and her mother because she was concerned

about them: Pauline was having serious problems with sleeping and feeding. She screamed too much, woke repeatedly, and took her bottle in snatches. Her mother was said to be at her wits' end.

I met Pauline and her mother, Mary, and I found a fair, thin, very young woman with a fair, thin baby of about two months. Mary sat with Pauline at a distance from her, facing outwards on her knee. Pauline sat stiffly, all her little fingers rigidly splayed, the very picture of anxiety. In response to my asking, Mary told me that although Pauline had always been rather unsettled, things had got much worse since they had both been ill. She, Mary, had been overtired and picked up some stomach bug which had had a very bad effect, but then Pauline had got it. Pauline had become seriously dehydrated with diarrhoea and vomiting, and she had been admitted to hospital. Her mother was persuaded not to go into hospital with her but to stay at home and recover herself. Pauline had come back cured but desperate. She refused to be comforted by her mother, she turned away from the bottle, she cried and could not sleep properly. Naturally she lost weight. Her mother became frantic with worry.

As the conversation continued, Mary volunteered more about her own life. She told me that her own mother had died when she, Mary, was eleven. Nevertheless, she had managed her schooling and was proud of having had a job at a well-known department store. She was married; she married at eighteen a young man of twenty who had been her boyfriend at school, and they had Pauline within the year. I had the impression that her husband simply did not know what had hit him. His parents were doing their best, but the extreme nature of Mary and Pauline's distress frightened them. On both sides the couple came from big families which were in one way warm and united; but they descended from generations where poverty and large numbers of children meant that individuals probably received little attention.

Mary's story evoked considerable anxiety in me. Equally anxiety-provoking was Pauline's half-starved appearance; they looked like my idea of a nineteenth-century workhouse pair, and yet I knew that there was no material lack—the young father had a very reasonable job. I suggested meeting again in a week's time. My anxiety was redoubled when a week later Mary told me that Pauline had slept less than ever and eaten less. She continued in this vein, and I felt I could discern a fury in her voice. I listened and eventually suggested that it must be quite upsetting, even annoying, when Pauline kept on saying no to the bottle. All at once Mary spilled out how bad she felt that she hadn't tried harder to breast-feed, how she'd been breast-fed herself; and then how angry she was with Pauline, how fed up she was with all of this, how she wished she hadn't got married; and then how dreadful she felt to be so furious with her own baby. Sometimes she hated Pauline. She wept.

I myself was filled with renewed anxiety. The session time had ended, and I did not know what to do. The only more encouraging sign was that, as Mary's tirade ended, Pauline and I looked at each other. Pauline leant towards me and gave a lovely smile. I instantly thought that Mary might feel envious—why should this stranger get acknowledgement? But no; Mary looked at me too. "She likes you", she said in quite a warm tone. I spent a worried week. I rang the health visitor, saying I was still concerned and urging her to visit. I awaited the next appointment with apprehension.

However, Mary presented with Pauline in a different mood. Pauline really had been eating and sleeping better; she had put on some weight. We talked about more general matters of managing a baby, and Mary asked if her husband could come next time. Indeed, he did come, and an optimistic atmosphere prevailed. I heard the story of a family christening where Pauline had been smiley and much admired—indeed, it was another baby who had cried. With this the family passed out of my acquaintance, and I am left thinking that Pauline must be of an age to have her own children by now. One can see how deprivation and loss can be passed down the years and wonder to what extent Mary's bereavement, against a background of generations of impoverishment, will have shown through in the next generation.

I said that I thought I had learnt from this case, and the question now is if we can learn something about overcoming obstacles with the help of a brief intervention from outside. What exactly was the obstacle in question? First of all, Pauline was being deprived of what she needed. Something had disturbed her to the point where she could not take in what her mother wanted to give. It looked as if this had been going on to some extent even before the pair were taken ill. We may speculate that Mary had a specific difficulty in becoming a mother which was connected to her bereavement. Certainly she spoke of her mother's death early on in the first meeting as though she was aware that it was important. It is a serious lack when a teenage girl does not have a mother in vigorous middle age, able to deal with some of the conflicts

and stresses aroused by adolescent development. Instead, Mary had a gap where that mother should have been; perhaps also a gap in her own process of maturing which she bridged by latching on to a boyfriend at school and hurrying into motherhood. It was as though Mary felt, as a smaller girl can do with a doll, that you can grow up by magic and be a mummy if you have a baby. Pauline was of course not a doll but a living human being with emotions and anxieties all her own to contribute to the relationship. Most, perhaps all, first-time mothers struggle with the feeling that they can't manage at times—the unconscious feeling that they are elder sisters left in sole full-time charge of the baby, rather than grown women assuming with some effort the task of becoming a mother. What sustains them in the ordinary way is not only the actual support of partner or grandmother but also the inner and unconscious sense that the mother of their imagination is helping them. Mary was feeling totally let down, as though her mother had deserted her.

It became clear how angry she felt, and how Pauline seemed a living reproach. Every time Pauline refused her bottle or cried inconsolably it was as though she were saying to her mother, "You aren't a proper mother, you can't breast-feed, you're just a child pretending". Mary felt Pauline despised her. When things broke down and they both became ill with persecutory pains and vomitings it seemed to mother and baby, we may imagine, as though their worst fears had been realised—all goodness gone, a sense that must have been increased for Pauline by the loss of her mother when she was admitted to hospital.

What was it that enabled them to recoup? There is no doubt but that both of them did have resources, just as Mary did actually have a husband and a mother-in-law who were concerned. In a psychoanalytically based intervention we value the power of the transference and have faith, based on experience, in change taking place as a result of something actually happening in the room. In this intervention a relationship, operating on an unconscious level, sprang up unbidden. Mary felt that I had understood the seriousness of her anxieties. This is partly confirmed by the strength of the anxiety I took away and carried around. I was really worried about her. One could say that Mary felt looked after, as though her internal mother woke up and started to take notice. She felt that she was in the presence of someone who would do her best not only to look after her, but also to look after her baby; someone who could think about two people at once. This was confirmed when she noticed that Pauline smiled at me and was pleased. It made Mary feel

as though Pauline wasn't so damaged after all, just as she felt that she wasn't such an awful person, as she had feared, since I hadn't reacted with horror to what she told me.

Consequently, Mary was better able to take sympathy and help from her husband, who himself started to feel less useless and more manly. Both, together, looked after Pauline, who (like Edmund) cheered up when she felt that the fundamental relationships—between mother and baby and between a parental couple—were being repaired and when her mother became more able to keep an adult perspective, feeding and caring for her in a less anxious and agitated way.

The meaning of the baby

Each baby carries its own meaning for the parents who made it, just as all parents carry a charge of significance for their children which extends far beyond their individual personalities and acts. In psychoanalytic terms the oedipal cluster of thoughts, emotions, and phantasies or unconscious imaginings are central to the unfolding of our characters. The questions "Who made me?" and "Who brought me up?" are universal. In our unconscious minds the figures of mother, father, and siblings are present for ever: not as direct representations of the actual people in our families, but as something more complex. We do not have to have had brothers and sisters for our deep ideas about sibs to form and colour our relations with peers in the place we learn or work or live; and in our minds the figures of mother and father continue to influence us because they are indissolubly part of our world. A parental couple bring their concepts of what it means to be a father and a mother, and what it means to have a baby, to the creative act and the business of bringing up children.

In ordinary good circumstances having a baby is felt to be a hopeful thing, an optimistic step into the future. Parents are unconsciously identified with the creative mother and father of their imaginings, who are felt to be benign and encouraging to the new generation. However, these figures of the imagination do not have to be good; we are all still children at some level, prone to fearing witches and giants and bad gods who are against us, not for us. New babies stir us deeply, and when things go wrong we do not only respond as rational adults.

In both the examples just quoted the parents' faith, in becoming good parents who are supported from within by their own helpful

mothers and fathers, was shaken. Edmund's parents were shaken by the experience of repeated miscarriages, and they felt as though they must be getting something terribly wrong to be punished by failure time and again. It took them months to re-establish the idea of a couple who could get things right. For them, and also for Pauline's parents, the presence of a scared and jittery baby challenged their belief in their power to grow into parenthood. It seems as though the gods were against them. However, in both cases these were people who had had sufficient good experiences—no doubt starting in their own infancies—to be able to recapture the identification with kind, capable parents.

Complications associated with conception, pregnancy, or birth challenge a couple's inner resources and alter the meaning of having a baby. When everything is straightforward and a healthy baby is born to a couple who are united in their welcome and determined upon a joint enterprise, it is obvious that the weather is set fair: the natural ups and down of babyhood are likely to prove temporary and surmountable obstacles. In many cases where there are problems the eventual presence of a live baby overrides previous dread. But in some cases the facts surrounding a child's conception have a tendency to overshadow the child's early life.

For instance, twins were born to a couple whose previous little baby had died. These twins were a boy and a girl. The dead baby had been a girl. All through the twins' early life the mother was aware that while the boy prospered, the girl seemed discontented, difficult, mutinous. The father was less worried. It was as though the boy was free to live his own life, as though the sun were shining on him more than on his sister. It became clear that the girl meant something very different from the boy, especially to the mother. The child felt like a reproach to her mother, as Pauline had to hers. First, the unhappy ghost of the dead baby hung around her. The mother had been even more deeply affected than one might think and felt as though she had been robbed. This second girl seemed to look at her with an air of dislike and distrust. Difficulties multiplied, and perhaps were even increased by everyone's natural tendency to compare siblings; in this case of twins, one as easy and one as a problem. This girl was seen through a multiplicity of lenses which prevented her mother from seeing her as a straightforwardly good baby who loved her. However, the balanced state of mind of the father was a saving grace, and the parents sought some counselling—a regular

time set aside to think together about the meaning of this unhappy situation.

From the point of view of overcoming obstacles, a complex situation like this needs much thought and attention over the years. Adult co-operation, perseverance, and the determination never to give up meant that matters never deteriorated as they might have done and gradually the problems faded. The once acute difference perceived between the twins was replaced by a more steady view that each was an individual with a separate disposition.

Babies who bring their own difficulties

So far we have considered only babies who are fundamentally well. Clearly, if a baby is premature or ill there are serious obstacles to the ordinary processes of emotional development. Feeding, making a baby comfortable, keeping it company, are all desperately painful tasks for both child and parent when the child is labouring under this kind of disadvantage. Putting up with unbearable primitive anxiety is the task which Maggie Cohen writes about in her chapter. My argument has been that although the levels of pain are extreme when circumstances are extreme, the process of absorbing and acknowledging pain is the same in ordinary infancy, and that the struggle to keep paying attention is central.

David

Prematurity is a disadvantage whose effects can be mitigated. I remember years ago when I was working in brief counselling with parents and their under-fives, a mother came to talk about her two-year-old son, David. It became clear that she had two years' worth of things to tell me, a whole unprocessed narrative which needed attention and sorting out. David had been premature and had been in hospital for a long time. His mother, Helen, let the whole story of his unexpected premature birth tumble out. It seemed to have happened yesterday. But a factor she stressed again and again was how she had thrown herself into the care of the tiny infant. She stayed in hospital and earned respect from the nursing staff. She was just as good as a nurse, somebody said. It was as if Helen clung to this suggestion and identified herself with her over-idealised idea of a perfect nurse—someone always calm and capable,

someone who never panicked and always knew what to do. Any real nurse could say that this is not what a nurse feels like, but Helen was out of touch with the reality of what was going on around her, and out of touch with her own feelings, let alone the truth of David's feelings.

However, from the time when she took her baby home she felt overwhelmed by the vulnerability of this tiny person. She told of what a struggle the last two years had been. When I met him I met a toddler who embodied the phrase "all over the place". He could hardly settle to anything. He up-ended a box of small toys, he clambered on the furniture, he tried to get into my desk drawers and my handbag. David could not sit peacefully for a minute and he could not play. His mother asked tentatively whether I thought he had ADHD. I thought there were other ways of understanding what the matter was.

To begin with, as I have already said, the narrative of David's life was far from clear in his mother's mind. The story was infused with anxiety and his mother's sense of guilt and resentment. What had gone wrong? Helen had been unable to think over the events of his life. Certainly, she had been able to brood upon them—but not to think about them in a way which enabled her to make some sense of them and get on with the job of bringing him up. She was still regarding him with immense anxiety. As she watched him climbing about she said, several times, that she didn't know what to do with him—he wouldn't stop. David was being given the experience of being unmanageable. His mother was depressed and agitated.

Subsequent conversations showed how Helen found it hard to help David with becoming able to think about how he was feeling. She had originally found it too excruciating to bear witness to his distress and to acknowledge her worry about his survival. This situation was continuing. She could not see how his jumpy, unhappy behaviour, veering between clinginess and outbursts, was a manifestation of baby anxiety. Instead, she was frightened that something was deeply wrong with him. The medical staff had always been reassuring about David's development, but she was convinced that they were mistaken. David, of course, was indeed conveying that something was wrong—but it was not simply physical.

It is common for children, particularly little boys, to become over-anxious and over-active when their mothers are depressed, whether or not prematurity is an issue. They feel their mother is unreachable, that their messages are unheard, and their attempts to rouse her

get increasingly desperate. Their wish to bring a smile to her face is unfulfilled. For David, this had started very early. His mother had taken refuge in efficient and busy caring activities, but was mentally out of touch with the baby trying to reach her. Now she needed help to think about his current unmanageable anxiety, the direct descendent of his earliest states, as well as to think retrospectively about their time in hospital which haunted the family like unfinished business.

Kaya

Here is an example of another baby, Kaya, who is causing anxiety because she has been born with a slight internal abnormality which will need surgical intervention. We see parents who are not quite in touch with how worried they are, and a baby who is restless and anxious.

At this point in the observations Kaya is six months old. Her operation is imminent. Her parents have been reassured that a favourable outcome is likely (and so it proved to be) but beneath the surface all is anxiety. The family consists of Kaya's mother, Ann, her father, Derek, and her much older sister, Tara. Ann is usually very chatty and cheerful, even over-bright. But today she is obviously finding things too much. She and Kaya have spent the day at grandma's house.

The observer comes in to the living-room where the television is loudly playing. Kaya sits with her back to it and mother is feeding her on rather surprisingly lumpy food. "I'm trying to get her to chew", she says. "Mmmmm, you need to chew", she tells Kaya as the baby appears undecided, wrinkles her nose and lets a large lump fall out of her mouth. Kaya turns her gaze to the observer. Ann offers another spoonful. "Chew!" Rather than chatting away as usual Ann focuses her attention fixedly on Kaya. "This bowl seems never-ending", she says. Kaya continues to gaze at the observer as she plays with the food with her tongue. "That's it, chew, good girl!" Kaya remains fixated on the observer. "Don't stare, it's rude", Ann says, but Kaya ignores her. Mother speaks to the baby in an increasingly high-pitched voice, and rather insistently.

Derek comes home. He says hello to everyone and "Hiya!" to Kaya who returns a welcoming smile. Ann continues to feed her. Derek goes out but soon comes back to sit down. "How's she been?" he asks. Ann explains at length that as soon as she got home from her mum's Kaya started to cry continuously. Ann thought it was her teeth and gave

her teething gel, but in the end she calmed down a bit. She says it was "weird", because the baby was fine at her grandma's but as soon as she got back home she began to cry and wouldn't stop. "I had to get Tara just to sit with her for five minutes—I needed time out, it was so constant". Derek nods. "This bowl is never-ending", says Ann again. "If it was pudding you'd have eaten it", she tells Kaya. Kaya coughs. She seems to be choking. She swallows. Tears form in her eyes. "Chew, chew, choo like a train", says her mum.

The meal continues, and Kelly does get some custard which she eats more easily. At the end the exhausted Ann asks Derek to sit with Kaya while she goes outside for a cigarette. Her father plays lively games, clapping, snapping his fingers, bouncing her, but half-watching the television himself. The observer worries inwardly that the baby might be sick—she ate a big meal and is now being tossed about. This doesn't happen but just before the end of the observation Kaya throws herself backwards in a violent arching movement on dad's lap and gives three loud, disturbing, high-pitched screams.

At this point in time Kaya is being asked to bear extra anxiety, the anxiety which her parents can't quite cope with and absorb. Kaya is thrown back on the reserves of good experiences which she undoubtedly has had, but which are under pressure. There is a background of the bright and over-jolly approach which in this family is associated with trying to cheer themselves up. It masks or even denies worry. This is in evidence from the start with the loud unwatched television filling in the background silence. Against this background Ann is making Kaya take in food she doesn't like. The food is lumpier than anything the observer has seen Kaya have before; it is unwelcome, but Kaya is making an effort to comply. It suggests that Ann herself is burdened with unwelcome anxiety. This must surely be linked with anxiety about the baby's physical state and her forthcoming operation, thoughts which the mother finds it hard to assimilate and digest. She seems to be feeding Kaya with anxiety, spooning it in with the hard lumps.

It sounds as though they were both more or less all right while they were at grandma's house and grandma was there to look after her daughter a little, but once the two of them were home again Kaya sensed her mother's anxiety and broke into sobs which could hardly be comforted. Ann for her part admits that she found it too hard to bear the sobs and had to have "time out", as if the idea of her baby suffering was too much for her.

Kaya gets full up with all the lumpy stuff, both literally and metaphorically, and chokes on it. At the end of the meal mum is full up too and has to go outside. Dad resorts to his joking and bouncing the baby, as if to throw out the anxiety, and doesn't really concentrate upon her. The observer fears it may cause Kaya to throw up, as though the whole experience were too much to take in, and at the end Kaya gives disturbing shrieks. The observer feels these to be anguished. Dad ignores them and watches the TV.

What we see here is a baby being brought up in an everyday family by ordinary good parents. But what we also see is how hard they are finding it to confront the idea that Kaya may have an unpleasant experience in store in hospital. Even more difficult are all the associated ideas about her vulnerability which must be present, at least unconsciously. No matter how rationally they seek reassurance, Kaya's parents, like all parents of a child who needs hospital care, are brought up against the fact that we cannot protect our children from everything, and we cannot even keep them alive simply by willing it. Ann is expressing the fact that fate is forcing an unwanted experience on her baby and herself, and Derek too is expressing, in his lack of attention, how helpless he feels. The overall effect is to leave Kaya alone with the worries which they convey to her.

What a relief for the whole family when Kaya's operation was successfully carried out and when they could return to a state where their trust in a reasonable degree of good fortune was restored. It seemed as though Kaya's parents' trust in their power to look after their baby was challenged, as was inevitable, but the result was to pass on to Kaya anxieties which they could not deal with themselves—at least at this particular moment in time.

Conclusion

The main theme of this chapter—overcoming obstacles—has been to consider the basic ways in which a child is helped to develop resilience in the face of difficulties, with some thought about the challenges that face parents in painful circumstances. But although all the families that have been described here were facing some degree of unusual difficulty in their children's lives, the process which takes place to try to overcome the difficulties is the same process that takes place constantly in the bringing up of any child.

A child is dependent on the help of a more grown-up person whose reserves of psychological strength and of life experience are greater. But help does not always mean removing the difficulty. In some situations that would be undesirable. For instance, if a child is having difficulty in learning to read, the solution is not to take away the book; indeed, the more this is done, the more the child will feel the adult agrees that reading is too hard for him or her. The solution is far more likely to lie in acknowledging that there is a difficulty but sticking it out and persevering, despite all the unpleasant emotions that trying to read are arousing. This is true even in grave circumstances where a straightforward solution is impossible. Every anxiety faced, every difficulty worked through rather than evaded, brings a growth in emotional muscle. The more that an infant or a child has close contact with adults who can bear this process, the better. Then there is a chance to develop increasing strength, and the growing capacity to deal independently with obstacles that lie in life's way.

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