

Theodore Lidz

The **Neonate**

and the

New Parents



The Person

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The Neonate and the New Parents

The birth of the baby marks a long-awaited moment. The expectant parents have spent many hours wondering about their future child, whom it will resemble, its future accomplishments, and what their child will mean in their lives. However, the wife with the fetus growing within her has been particularly given to daydreams. Her reveries have recaptured the crucial turns in her own life that led to her marriage and her pregnancy, and her fantasies reach into the distant future of the life waiting within her. She awaits the affection she will give and receive; and her daydreams, now as always, seek to evoke compensations for the frustrations and disappointments in her own life. Days of comfort and expectant hope are interrupted by periods of discomfort and anxiety. Although the first-born are in a minority, they require our attention for they usually present a more critical experience to the parents, profoundly altering their lives, bringing new sensations and awareness, and creating problems and questions for which they seek more guidance.

The Expectant Mother

“Morning sickness,” with nausea and occasional vomiting, often disturbs the first few months of the pregnancy; but if the woman is mature and happily married, the pregnancy soon turns into a period of blooming when she experiences a sense of completion and self-satisfaction. Even though the mother may have been happily pursuing a career, she now feels that she is fulfilling one of the significant ways of being creative open to her, a way given only to women. She finds a new sense of closeness and sharing with her husband that forms a new and strong bond between them. An appearance that reflects happiness and contentment augurs well for the course of the pregnancy and for the child. Gradually, however, the expectant mother usually turns inward, often from the moment when she first feels the fetus move and she knows that she has a living being in her womb. She experiences a self-sufficiency because the most important thing to her is within her, and her own life and her own needs have become secondary to perpetuating herself and the species through the baby. Her husband may feel excluded and neglected, for he is no longer the primary recipient of her emotional investment. Yet he is more important to his wife than ever, for she can relax properly and invest her emotions in the fetus only when she feels

secure, protected, and supported by her husband.

As much as the woman may enjoy her pregnancy, she eventually grows impatient. Her increasing girth makes her feel awkward; her balance becomes insecure; often she tires more readily; the movement and kicking of the fetus are annoying; and after the baby's head descends and engages her pelvis, she must urinate more frequently. Both parents are impatient to know how it will turn out, properly experiencing some concerns—not so much for the mother, for maternal deaths have become a rarity, but wishing to know that the baby will be normal. (Anomalous developments are sufficiently common to justify some concern.) The parents have also been limited in their fantasies, for they cannot know the sex of the child. As many parents feel disappointed if the child turns out to be of the opposite sex from that awaited, they tend to hold their imaginations in check, or are willing to consider both alternatives until they are certain.

Prenatal Influences

The emotional problems of the pregnant woman can affect the course of the pregnancy and the fetus. The influence of emotional turmoil in causing spontaneous abortions and serious physiological disturbances in the mother, such as pernicious vomiting or toxemia, is beyond the scope of this book except as an indication that the fetus is not totally protected from physiological imbalances of the mother. The baby's development does not start at birth but with conception. It is responsive to its fetal environment. If the mother bleeds seriously or if there is a marked disturbance in her metabolic equilibrium, the fetus may develop an anomaly through interference with its maturation.¹ It has become clear, particularly through the studies of Sontag and his coworkers (Sontag, 1941, 1944), that the mother's emotional state can influence the fetus. We are not concerned with superstitions that a child develops a harelip because the mother saw a rabbit, or that Annie Oakley's mother was frightened by a shotgun. Even though no direct nerve connections exist between the mother and the fetus, there is a neurochemical bond through the placental circulation, like mother's internal secretions can produce changes in the fetal heart rate, in its bodily movements, and perhaps in its intestinal activity. Spelt's (1948) studies have shown that during its last two months the fetus not only responds to loud noises but that its heart rate can probably be conditioned. There is evidence that the newborn of disturbed mothers may tend to be hyperactive in their responsivity to stimuli, and have more labile heart action and

gastrointestinal functioning (Sontag, 1941. 1944; Spelt, 1948). However, any tendency to consider such newborn as neurotic at birth constitutes a very dubious extrapolation of known facts. While reasonable evidence indicates that undue sensitivity in the neonate can be related to the mother's emotional state during the pregnancy, we must also realize that such mothers are also likely to remain upset after the delivery when the baby's well-being depends upon her conscious and unconscious attitudes toward her infant rather than directly upon her physiological processes.

The Newborn's Appearance

The obstetrician reassures the mother and informs her of the baby's sex immediately after the delivery, without waiting for any questions. Despite such reassurance, many parents must stifle some feelings of disappointment when they see their babies, and hesitate to express concerns that a newborn's appearance may arouse in an inexperienced parent. The newborn is not very prepossessing, and it may take all of the mother's maternal lore not to be disappointed with the creature to whom she has just given birth. The infant possesses the many endowments and assets that have been reviewed in the preceding chapters, but most of them are not yet apparent. Let us now take a more careful look at the infant who has just started life in the world beyond the womb.

The average baby born at term weighs seven and a quarter pounds and is twenty to twenty-one inches long. With its knees flexed and body curled in its familiar fetal position, it seems very tiny indeed, particularly when the obstetrician or nurse skillfully holds it on a hand and wrist. Somewhat wizened, the baby may appear more like an elderly denizen of the world than a newcomer, for there is little fat—in particular, the fat pads that will fill out the cheeks are missing—and the jaws are unsupported by teeth. The hair may be dark and straight, coming low over the forehead and conveying a hairy appearance that deprives the infant of resemblance to any known relative within the last ten thousand generations. Such hair, when present, will soon be replaced by hair so fine that some babies appear bald to casual observation. The vernix caseosa, a cheesy material which covers the body, provides a protective coating for the skin, like skin is reddened, moist, and deeply creased. The "caput," or swelling formed by pressure during the passage through the birth canal, may have temporarily deformed the nose, caused a swelling about one eye, or elongated the head into a strange shape. The skull is incomplete, for the bones have not joined in two areas called the "fontanelles" where the brain is covered only by soft tissues. The

external genitalia in both sexes are disproportionately large due to stimulation by the mother's hormones and will regress in size. The breasts may be somewhat enlarged for the same reason and secrete a watery discharge discouragingly termed "witch's milk." The irises are a pale blue, which does not indicate a resemblance to either parent, for the true eye color develops later. The head, even though its contents are not fully developed, is very large in proportion to the body, and the neck cannot support it; whereas the buttocks are tiny, creating an appearance that is very disproportionate in comparison with adult dimensions.

The Neonate's Physiological Instability

The baby is arbitrarily termed a "neonate" for the first several weeks when control of the physiological processes remains unstable. The regulation of the body temperature is imperfect and breathing is often irregular. The eyes wander and cross. The newborn can hear little during the first twenty-four hours until air enters the Eustachian tubes. The neonate seems to prefer its former home and acts as if it resents any stimulation. It will sleep about twenty hours a day, its slumber broken primarily by crying that signals hunger—it needs milk from six to eight times a day. The infant's primary needs are sleep, warmth, and milk to continue maturing outside the mother.

TOTAL DEPENDENCY

Despite the diffuse and unorganized nature of the neonates' feelings, which we can, of course, only surmise through observation of their reactions, these first weeks of life receive much emphasis in the study of personality development—perhaps more because of how the parents' attitudes toward their child are established than because of the direct impact of events upon the infant. Neonates are virtually helpless but also passively omnipotent, for all needs are provided for by others. Their comfort and well-being depend upon the ability of mothering persons to understand their needs and satisfy them. The baby's future emotional security rests to a very great extent upon the development of a mutuality between the infant and the mother that permits them to interact on a nonverbal basis during the first year and provides the mother with empathic feelings for its needs. Neonates have little tolerance for frustration and can do little toward directing their mothers' efforts except to signal discomfort, and it is up to the mother to adjust to the infant. The ability to give birth to a baby does not assure the ability to

nurture and properly care for one. Maternal feelings may be stimulated hormonally, and inborn responsivity may be stirred by certain activities of the infant, but such feelings do not provide the necessary skills, nor are they adequately pervasive to overcome the emotional problems aroused in many women by the tasks of mothering.

THE NEONATE'S BEHAVIOR AND CAPABILITIES

Although we are apt to think of newborns as tiny creatures whose nervous systems are still too incomplete to react to anything other than their physiological needs or to relate to the world, the careful observer will note a fascinating variety of behaviors and a definite capacity to begin to build upon experiences virtually from the time of birth.²

It has, of course, been apparent that neonates possess important ways of interacting with the world about them. They can suck and will start to suck when a nipple or anything else is placed in their mouths. At birth, or soon thereafter, babies reflexly turn their heads to the side of a stimulus to the lips and start to suck. They cannot yet properly grasp the nipple with their mouths unaided. The lips and mouth are all-important to the neonate, and the oral area is highly sensitive, richly endowed with tactile sensory receptors. Indeed, a fetus will respond reflexly to stimulation of the oral zone long before birth. The neonate's hands tend to be held closed, and if something rubs the palm, particularly if the area between thumb and forefinger is stroked, the hand reflexly clenches it and holds on with a strength that suffices to support the baby's weight if both hands are grasping. This innate "grasp reflex" serves no apparent purpose in the human infant but was of utmost importance in the last prehuman phase of evolution when the infant had to cling to its mother's hair. The grasp reflex lasts from four to six months until the forebrain matures and the nerve fibers that conduct impulses to the upper extremities are covered by a sheath of myelin which permits babies to begin to use their hands to make voluntary discrete movements. If the baby is dropped, or is suddenly jerked downward, or is startled by a loud noise, an immediate reflex change from the usual curled posture occurs as all four extremities are flung out in extension and the infant starts to cry. This "startle" or "Moro" reflex may have served to help a simian mother catch a falling infant by causing it to spread out to a maximal extent. Playful dropping motions that excite and please an older child terrify the young infant.

Several other reflexes require note. For some weeks after birth, a baby, if held erect with toes touching the ground, will make reflex stepping movements. However, they do not indicate that this is an extraordinary youngster, prematurely ready to learn to walk, any more than the swimming movements the baby makes when properly suspended warrant a try at swimming. Stroking the outer side of the sole of the foot to test the “plantar” reflex causes a fanning out of the toes and an upward movement of the big toe, termed a “Babinski” response or reflex. It is an abnormal response in adults but indicates in infants that the pyramidal tracts of nerve fibers, essential for voluntary muscular control, are not yet covered by the myelin sheaths necessary for their proper functioning. Until the Babinski response disappears toward the end of the first year of life, the baby cannot voluntarily control the lower parts of the body. The upper extremities can be controlled sooner than the lower, and the infant will be able to start practicing finger control before becoming six months old. Thus the infant’s ability to handle things, maintain balance, talk, walk, and control sphincters awaits the maturation of the nervous system, rather than practice and training alone.

Sleep

During their first days of life neonates spend about three-quarters of the time sleeping. The irregularity of the sleep and the baby’s sudden startles during it may puzzle and even disturb some parents. Neonates have two or three rather distinct types of sleep. In *regular* sleep, their breathing is smooth and even but with spontaneous startle reactions (mostly of the extensor, Moro type), sometimes occurring every two minutes but with longer relatively undisturbed periods. In *irregular* sleep, startle reactions are much less frequent but breathing is irregular and erratic, and there are numerous muscular movements, including a variety of facial grimaces and mouth and tongue movements. At times, the infant falls into an intermediate state of *periodic* sleep, when bursts of deep and slow breathing alternate with very shallow breathing that may be almost imperceptible (Wolff, 1966, pp. 7-11).

Wakefulness

The neonate’s waking life varies between states of drowsiness which are transitions between sleep and wakefulness, alert inactivity, waking activity, and crying (Wolff, 1966).

States of *alert inactivity* are of particular interest because it is during such states that infants begin to assimilate from the environment and we can note the beginnings of their cognitive development. States of alert inactivity occur most frequently when the infant is relatively free from tensions such as hunger. At such times the baby's face is relaxed, its eyes are open and have a bright and shining appearance, and there is little motor activity other than eye movement. Although periods of alert inactivity may not occur in the first day or two, or may last for only a few minutes, occasionally a newborn baby may be alert and inactive for over a half hour at a time. While in this state, if an object is placed in the neonate's field of vision long enough, the baby will follow it with its eyes as it is moved back and forth; and it will turn its eyes and head to the right or left when a sharp, clear noise is made, as if seeking the source of the sound. Although the human face does not lead newborns to fix their eyes any more than do inanimate objects, the child's ability to gaze at a parent seems to establish a relationship of a sort, and thus can be very meaningful to parents.

During periods of *waking activity*, neonates kick, mouth, suck their hands, and cry intermittently. At these times breathing is grossly irregular, the skin is flushed, and the eyes, though open, do not shine as during states of wakeful inactivity. Active waking states are more common before than after feedings. During the first week or two of life, if the infant should begin to pursue an object visually while in this state, activity stops; but by the end of the second week general bodily activity can go on together with visual pursuit movements.³ Throughout the first month or so, infants pay attention to new or recently acquired patterns only when inactively alert, as if the assimilation required the involvement of their entire being. After the first week, it is possible to increase the duration of alert periods significantly by moving an object back and forth across the field of vision of the infant who is about to fall asleep. Clearly, neonates are already "interested" in stimuli that serve as "aliment" for their cognitive development.⁴

Crying

Crying is almost the only significant way in which very young infants can draw attention to their distress. The influence of different types of crying on parents is not as specific in humans as among some other species, and parents' individual interest and experience rather than the type of crying may determine their response. However, three distinct types of crying can be distinguished, and often serve as guides even though the parenting person may not be aware of it (Wolff, 1969). The rhythmical cry is

the basic pattern and is often set off by hunger.⁵ Wolff noted that, whereas more experienced mothers might neglect such crying for a time, some would respond by feeding, and others by checking the diaper first. It is of interest that rhythmical crying can often be stopped by passing an object back and forth across the baby's visual field to evoke a state of alert inactivity, just as the drowsy baby can be aroused by the same maneuver. Similarly, a sharp sound and, after the second week, particularly a high-pitched voice, will alert the infant and bring a cessation of crying. Perhaps more important, if the neonate is picked up and held against a person's shoulder, it will become visually alert, stop crying, and start scanning—a means by which good "parenting" affords the neonate greater opportunity for environmental stimulation (Korner and Grobstein, 1966).

The *mad* or *angry* cry is more preemptory than the rhythmical cry and usually leads parents to stop what they are doing and check on their baby, even though they may not be alarmed by the expression of rage. Crying caused by *pain* usually leads parents to respond immediately and anxiously. It starts with a long cry followed by an extended period during which the breath is held in expiration, and may continue in this pattern.

When about three weeks old, the infant develops a new type of crying that seems to indicate a desire for attention. The crying is low in pitch and intensity and resembles long-drawn-out moans which occasionally become more clear-cut. Such crying, as other non-crying vocalizations, first appears when the baby is fussing but before actually starting to cry. The novel sound produced serves as a "circular reaction," which the baby practices when alert and thereby gains a new skill (Wolff, 1969). Thus, before infants are a month old they are acquiring ways of obtaining attention.

Laughing

Toward the end of the first month, the infant also displays a more affable way of relating. Many infants will chuckle and laugh when stimulated in their armpits or on their bellies by gentle but firm and rapid finger movements, though not by tickling. However, here, too, neonates' responses depend greatly on their states of arousal. Parents can become quite confused by their infant's different responses to the same stimuli according to the state of arousal. Cooing and playing pat-a-cake, which produce a smile in the three-week-old when in an "alert inactive state," can provoke crying when the infant is showing mild

discomfort by soft moans or diffuse activity; and the silent, nodding face that usually elicits a smile can lead a fussing infant to start to cry.

DIFFERENCES AMONG NEW BORN INFANTS

Even casual observation of the newborns in a hospital nursery reveals that they differ greatly in appearance and temperament. Some are fairly well fitted out and others appear somewhat premature. Some infants are naturally “cuddly” and easy to hold, whereas others are loose and sprawling, or rigid, when held. Some are placid, sleeping most of the time, and others are sensitive to stimuli and their needs are not so easily satisfied. Newborns, therefore, require somewhat different management of their needs, and start to experience the world on a somewhat different basis (Escalona, 1962).⁶

The parents, particularly the mother, soon after the child is born, adjust to the specific characteristics of their infant. A mother who may previously have interacted very well with a calm and docile first child may grow anxious when confronted with the care of a hypersensitive infant; or, on the other hand, a woman may grow concerned or even dissatisfied with a baby who is quiet and relatively unresponsive, needing greater reactivity in the child to stimulate and satisfy her. The innate characteristics of infants can start a chain of interactional responses which may persist and greatly influence their development, or which may alter either as they change as they mature or in response to their parents' handling.

THE FAMILY MATRIX

The birth of a child, particularly the first child, produces a change in the parents' lives. Their lives and well-being are bound to the child's life for many years to come. The family unit undergoes a reorganization in order to provide room for the infant, and the roles of husband and wife alter to embrace the roles of father and mother. Although the mother is traditionally and rather naturally more involved in the care of the neonate, the relationship is too often regarded as if the two were living in a vacuum rather than as part of a family. The concentration of attention upon the mother and her child provides a useful focus, but often leads to neglect of highly significant influences affecting the relationship. The birth of a child, particularly the first, is a time of trial for many marriages. The division

of tasks between parents shifts, and many mothers may give up, or at least suspend, their careers for a time. The family income is likely to diminish while expenses rise. Fathers who share the nurturant functions are, like mothers, more bound to the home and must forgo some recreational activities. Anger and irritation with the infant frequently reflect unhappiness in the marriage as hostility is deflected from the spouse onto the child. The father must be able to share the mother with the infant and not feel left out, and the mother cannot exclude her husband from her life and the child's. A couple who had purposely remained childless for five years in order to enjoy their own lives unhampered by parental responsibilities finally had a baby at the wife's insistence. The husband was a person who required constant bolstering of his self-esteem by admiration from women, and although promiscuous demanded his wife's complete attention. Soon after the baby was born, the mother found herself in a dilemma. When her husband was at home, each time she went to feed her son or paid attention to his cries, her husband would voice an imperative need and throw a tantrum if the infant's needs took precedence over his. He refused to forgo any social activities, and when babysitters were not available insisted that his wife bring the neonatal infant along to noisy drunken parties. As the son grew older, the father's jealousy and rivalry increased, and he constantly belittled his son's abilities while holding himself up as an unattainable model of masculine achievement. This mother could have provided adequate mothering only if she had broken off her marriage. Immature spouses are likely to behave even more immaturely when they become parents, particularly when they have married primarily in order to regain a parental figure to care for them and then cannot share their spouses with their children and accept parental responsibilities.

Fortunately, the infant usually creates new ties between the parents. They are united in their common product and become involved in experiences with their child that no one else can really share with them. The baby gives their lives new purpose and direction, and a sense of continuity with a new generation. The influence of children upon the lives of their parents will be discussed in Chapter 15.

When the new infant is not the first-born, brothers and sisters are not only affected, but their reactions impinge upon the neonate both directly and through the impact of their altered needs upon the parents. They are supposed to welcome the new sibling but almost always feel that the baby is an intruder who preempts the parents' attention and affection. The older child frequently regresses, unconsciously seeking the benefits of greater dependency, and requires more care and demonstrations of

love than previously. The parents may become perplexed and frustrated in their efforts to provide for the infant while they are caught up in the obvious unhappiness of their older child. Many contemporary parents, aware of the jealousies aroused, seek to prepare the older children for the birth, consider their needs, permit verbal expression of hostility, and seek to compensate for the attention they give the infant and try to find ways of making the advent of the new child advantageous to the older children.

THE MUTUALITY BETWEEN MOTHER AND INFANT

Although the sharing of nurturant functions by both parents has become more prevalent, increasing the father's investment in the baby and making the mother's tasks less burdensome and more pleasurable, the mother almost always assumes the major role in caring for the infant and particularly the newborn infant. The infant properly needs to have an adult who intuitively knows its ways, and to whose ways the infant can learn to respond. The mutuality between mother and child which seems essential to enable the mother properly to empathize with the infant's needs and feelings, and to bestow love and tenderness, usually develops during the pregnancy rather than appearing suddenly after the birth. The fetus is part of the mother, and the love of the infant is properly partly a narcissistic love—not fully distinguishable from the woman's love and concern for herself and her pride in what she can produce and achieve. The pregnant woman's life, the investment of her thoughts and emotions encompass the fetus which gives a new and expanded meaning to her own existence. When properly developed, such investments continue to enfold the helpless infant, who continues to develop through the mother's care almost as completely as when within her womb. The differentiation of mother and child is a lengthy process for both, continuing over many years, as we shall examine in Chapter 5.

Although the mother seems to have a more natural unity with the infant, the sensitive father also becomes involved in the development of the fetus. He wonders what his wife's experience is like, feels her enlarging womb, thrills at the first signs of life, tries to ease her days as she grows awkward from her change in shape, and muses about what he will do with the boy or girl in the years ahead.

All sorts of interferences with the development of proper parental preoccupation with the developing infant can arise. Thus, a young and immature woman had married on the rebound and considered her husband inferior to her. She became infuriated when he did not idolize her and cater to

her adolescent whims but expected her to assume responsibilities in their marriage. She had never really accepted the finality of the marriage, daydreaming that her former boy friend would realize his error, divorce his wife, and return to her. Her resentments welled up when she believed that her husband had purposefully impregnated her in order to hold her in the marriage. As the pregnancy progressed, unable to accept the reality, she spent more and more time lost in a fantasy of an imaginary life with her true love. She scarcely thought of the fetus within her and became annoyed by every movement or kick that encroached upon her daydreams, irritable and antagonistic to her baby before it was born. More tangibly perhaps, a woman already harassed by the care of six young children—a task amplified by her perfectionism and her concerns when they were out of her sight—finds that she cannot make room, emotional room within her, for the coming baby.

Even though the parents' fundamental emotional attitudes toward their baby involve their own personality development, their maturity as a man or woman, their happiness in their marriage, and other such factors that can scarcely be influenced by direct instruction, their insecurities over everyday, seemingly trivial matters of child care can create despair concerning their ability to care properly for and satisfy their infant. They must learn new techniques that sound so rudimentary and are so often taken for granted that they feel ashamed to admit their ignorance and seek help. The mother must, for example, if she breast feeds learn how to get her nipple into the baby's mouth and how to hold the infant securely. She does not know without instruction how long the baby should nurse or how frequently to feed. Diapering, cleaning, bathing, deciding how much the baby should be handled and how much left alone, and many other such items can provoke indecision. Sometimes nothing may seem to go right, usually because of the uneasiness and anxiety concerning her techniques and abilities that advice or instruction could dissipate. The turmoil can start family frictions, lead a wife to wish she had stuck to her career and eschewed motherhood and cause her husband to doubt his choice of a wife. Instruction in the elements of child care and making advice available to the young parents are particularly important in contemporary life, as traditional techniques are poorly conveyed and often mistrusted as old-fashioned and unscientific.⁷

The advice offered by those considered to be, or have considered themselves to be, authorities on how to raise children has changed several times in the past half century, adding to parents' confusion.⁸ Recent teachings have urged parents and teachers to seek to meet children's maturational needs at each

phase of their development—neither to place demands before children are capable of meeting them nor, on the other hand, to restrain children from utilizing their abilities when they are ready either by continuing to do for them or by unnecessary restrictiveness.

Although differences of opinion exist concerning the older children’s capacities and what might be expected of them, virtually all experienced persons agree that neonates can do almost nothing for themselves other than carry out their essential physiological processes, and that attention must be focused upon the parents’ handling of the infant. Neonates have virtually no tolerance for frustration of their needs, and if they are born normally developed there is no need for them to experience repeated frustrations as the essential problems of the physical care of the newborn have been worked out.

MEASURES TO FOSTER MUTUALITY

During the past several decades, obstetricians and pediatricians have initiated various measures to improve the parents’ security and knowledge, and to foster the development of a satisfactory mutuality between mother and infant (Stendler, 1950; Vincent, 1951).

Prenatal Courses

Expectant parents, particularly those awaiting a first child, are often offered *prenatal courses* in which they are taught the essentials of the physiology of pregnancy, of fetal development, and of childbirth so that they may overcome misconceptions and fears arising from ignorance. Here, too, parents learn about the infant’s physical and emotional needs and how to provide for them. Such instruction, which usually includes an opportunity for free discussion, can help prevent mishandling of the baby as well as foster greater security in the parents. These courses also establish, even before the baby is born, a relationship between the parents and an expert, to whom they can turn if problems arise during the pregnancy or in caring for the baby.

Natural Childbirth

Many obstetricians promote the practice of “natural childbirth”—the conduct of the labor and delivery without anesthesia, or with minimal anesthesia—to permit the mother who is awake to

participate in a process that properly constitutes one of the most important experiences in her life.⁹ If a woman can relax during the labor and delivery and maintain the muscles of the pelvic floor in a reasonably relaxed state, labor is easier and less painful than when she is tense. Pain itself is bearable and often can be virtually ignored when it is not accompanied by fear. The woman who has gained confidence in her obstetrician and in herself, and who has been prepared by exercises that teach her to relax properly, can often cope with the pain experienced during a normal delivery without requiring narcotics and anesthesia. In a sense, "natural childbirth" has become feasible because of the advances of modern obstetrics that permit the mother to feel secure. Several types of anesthesia can also be used that permit the mother to remain awake and participate in the delivery. The essential mutuality is fostered, for she can immediately see and hold the infant she has brought into the world. The father now is permitted or even encouraged, in some hospitals, to be present during the delivery, to increase the meaning of childbirth to him and to implement his mutuality with both his wife and their child. Perhaps the effect upon the baby is almost as important, for if it has not absorbed a narcotic or anesthetic from the mother, the newborn is active and responsive, which fosters the establishment of a bond with the parents. The LaMaze technique, popular in France, seeks to ease the infant's entrance into the world by delivering in dim light and avoiding shocks such as the stimulation with cold water, etc. The value of the method is doubted by many and its safety challenged by some.¹⁰

"Rooming-In"

Many obstetricians have sought to foster the mother-infant bond by "rooming-in" programs, in which the newborn is kept in a bassinet alongside the mother's bed, where she can watch and take care of the baby herself. Mothers can often relax better with their babies close to them, secure that they are well. However, as most women now remain in the hospital for only two or three days, the importance of "rooming-in" has diminished.

Breast Feeding

There is an increasing trend to induce mothers to breast feed their babies. Breast feeding has many advantages (Aldrich, 1947). The mother's milk is rarely unsuited to the infant; it contains antibodies that help protect the infant from various infectious diseases; the suckling promotes contractions of the

mother's uterus, aiding its reduction to normal size following the delivery. There are other practical advantages, such as freeing the mother from the need to prepare bottles; and contrary to expectation, breast feeding often permits greater freedom of movement, for the baby's food goes along with the mother. However, we are here interested in its promotion of a relatedness between mother and child. It is, for example, difficult to nurse a baby at the breast without holding it closely and providing the stimulation and the comfort of body contact, the mother's odor, and the mother's face upon which the baby fixes its eyes. Suckling also properly stimulates genital sensations in the mother which help establish an erotic component to the mother's attachment and can add to the pleasure of nursing. Unfortunately, some mothers become uneasy because they are sexually stimulated and believe that something is wrong with them and cease breast feeding. All in all, breast feeding assures that the infant will receive a reasonable amount of maternal attention and contact and during the first months spend much of the intervals between sleep in its mother's arms.

Some women, however, have a deep aversion to nursing, experiencing it as if a parasite were suckling at them, and others may have a strong sense of shame about its animal-like character. A baby can thrive very well if bottle-fed, and the mother may relate to her infant better while giving a bottle. Pressures toward breast feeding can be injurious if they make a mother feel guilty or unworthy because she is not for it. Fortunately with breast feeding the problem often takes care of itself, for fairly reliable studies indicate that mothers who do not really desire to nurse, or have unconscious blocks about it, do not succeed and must wean the child after a brief trial (see Chapter 5).

Well-Baby Clinics

The pediatrician seeks to provide guidance for the mother in child-rearing practices. Efforts are made to maintain regular contacts even when the child is well and thriving. The physical development of the infant and young child is followed, prophylactic measures such as inoculation recommended and provided, and discussions of any problems stimulated. The mother learns that she can discuss her own emotional difficulties which might interfere with the care she provides her offspring. The interest of the personal pediatrician, or of the clinic, lies in the total well-being of the child and in the mother-child relationship rather than in the child's physical health alone.

These various measures can all be effective and have been very worth while when they do not contain moralistic implications that set expectations, spoken or unspoken, beyond the mother's capacities, and provoke in her feelings that she is inadequate or rejecting of her baby.

The mother's security and spontaneity of feeling for her baby are usually more important than the precise techniques used in delivering and nourishing the infant. If the mother is happy during her pregnancy, if she consciously and unconsciously wants the baby, feels close to her husband, and has become caught up in the miracle going on inside of her, everything else is relatively secondary. Although she may experience difficulties, the chances are great that she will learn to overcome them and her positive feelings will win out over fears of labor or her inexperience in caring for an infant.

A good start is important, for absence of good relationships can make new infants fretful, and the parents' inability to satisfy the infant can nullify the enjoyment of having a baby and establish a pattern that may be difficult to overcome. Still, babies' primary needs during the first few weeks of life are food, sleep, and warmth—they are not extremely sensitive to their parents' inexperience. The atmosphere established is probably more important than the precise details of management. Babies are handled in very divergent ways in different cultures and in some places in a manner that to us would seem deleterious, and yet the infants survive and flourish. Parents' insecurities are alleviated by training and instruction and the various measures outlined, which can, at least, modify or blunt the edge of anxiety-ridden handling and cover difficulties in accepting the baby. Fortunately, parents' anticipated rejection of a baby often fails to materialize, because babies in their helplessness are very seductive and difficult to resist.

The Unwanted Infant

Although one likes to believe that the birth of a child is a happy event for the parents, it would be unrealistic not to recognize that a baby is often unwanted and that one or both parents are emotionally incapable of welcoming it. Such situations are important to those interested in child care because it is among such children that difficulties in physical and emotional health are more likely to arise. About seventy percent of pregnancies are unplanned, but this does not mean that most of these babies are unwanted or unwelcome. Many were simply not wanted at the specific time; and others, though

undesired, are well accepted after the fact. Maternal rejection of a child and its serious effects have received much consideration in recent years. A variety of emotional and psychosomatic disturbances has been somewhat uncritically attributed to “maternal rejection” as if it were an entity. Whereas occasional mothers neglect their infants physically and emotionally and clearly do not respond to them properly, the matter is usually not this simple, for the mother’s difficulties are less global and more specific. Some women fear pregnancy and labor because of residual childhood fears; often these are fears that have been banished from consciousness since childhood rather than having been reevaluated and overcome, such as ideas that the baby is born by an operation, or through the navel or the anus, and that they will be mutilated through childbirth. Some are fearful of being caught in a situation over which they have no control, such as the growth of the fetus within them and its birth. Yet they may desire and very much love the baby. On the other hand, a woman may enjoy being pregnant because of the attention and care she receives during it but have difficulties in being maternal to the baby because she seeks to be cared for as a child herself. A common cause of rejection of a child is the anger at being tied to an unhappy marriage, with the wife feeling that the husband *made* her pregnant—or, conversely, that a wife purposely became pregnant to prevent a divorce. Other women resent being kept from their occupations, which are more important to them than their marriages. Some women deeply resent their femininity, and can accept neither the pregnancy nor the baby which definitively challenges and destroys fantasies and self-deceptions of not being a woman. There are a wide variety of reasons, conscious and unconscious, why a woman can have problems with one or another phase of pregnancy, with childbirth, or with child rearing. Some who fear pregnancy or childbirth and have sought to avoid them may make excellent mothers after the child is born, having lived through their fears and found release from them.

Of course, one cause of “maternal rejection” is paternal rejection or disinterest in the baby and the refusal of the father to share the tasks of caring for the child. A woman may also resent an impregnation and its product that was more or less forced upon her by her husband.

We cannot here consider those pregnancies of deprived adolescent girls who want a baby as a doll to care for, but have no use for the child after it is old enough to require more than doll-like care; or who need to become pregnant to prove themselves or to satisfy a boy who must prove his manhood by having his girlfriend’s belly “stick out”

More deep-seated emotional problems that involve the entire personality development of the parents are little influenced by instruction or techniques of improving a parent's relatedness to the child, and can even be very resistant to intensive psychotherapy. We have noted instances of such difficulties in the man who could not accept a child that interfered with the attention he needed from his wife, and in the woman who still sought to be mothered by her own mother and to be her husband's child.

The availability of very effective contraception and of therapeutic abortion when necessary are means of avoiding the births of unwanted children and particularly of children born to parents who cannot accept them or nurture them. Unfortunately, as we shall consider in the chapter on parenthood, reason does not always hold sway in such areas, and many people have children they are incapable of raising.

The Infant's Gender

The sex of the child is one of the most important factors that influences the parents' ways of relating to the child, regardless of whether they wanted a child of the given sex, are disappointed because of it, or truly had no preference. Even though boys and girls are cared for in much the same way while neonates, the child's gender stimulates subtle differences in parental handling and responses that are part of the covert training of the child to behave as a boy or a girl. We shall, however, defer considering the influence of gender upon the child's development until Chapter 7.

Often enough the gender of the child evokes disappointment in one or both parents—the father who wants an heir, or a boy he can raise to be a quarterback, or a son to take over his business; the mother who wants a daughter who will become more of a companion than her son, or who wants a boy to live out her fantasies of what life would have been like had she been a boy. A wife may feel rejected if she cannot produce a boy, even though she may consciously know that it is the husband's chromosomes that determine the sex of the offspring. She has such examples as the shah of Iran, who, despite the availability of excellent medical advice, divorced a wife because she produced daughters rather than the needed male heir.

STABILIZATION

The infant's physiological processes become considerably more stable by the end of its first month; breathing becomes regular, body temperature fluctuates less, and sucking becomes vigorous. The movements of the limbs become more or less symmetrical, but still random, though some infants can get their thumbs into their mouths to pacify themselves. The intervals between feelings of hunger have usually become more regular, but they are still brief and infants require five or more feedings every twenty-four hours. They enjoy a bath, its warmth, and the handling that goes with it, but protest if clothing is drawn on over the head—something to which infants seem to have an inborn aversion.

The nature of the neonate's world can only be reconstructed imaginatively. Although it seems to be dominated by the need for sleep and nutriment to foster growth and maturation, we have seen that, when in the proper state of arousal, the neonatal infant also assimilates sensations, and new stimuli can become more important than sleep. By the end of a month, infants' ways of reacting and relating have developed considerably from the reflex responses with which they were born. The mouth and lips—sucking and taking in—are central to infants' relatedness to the world in which they live; but almost imperceptibly their abilities have expanded through the use of sight, sound, and other ways of experiencing. Neonates do not distinguish between the self and the remainder of the world, including the nipple, whether flesh or latex, that comes and satiates and then disappears. Still, the baby is alive and responsive and in its undifferentiating way takes in sensations as well as milk—a satisfying closeness to the mother, her warmth, her feel, and her smell.

The lives of neonates differ from the onset. They are cleaned gently or roughly, bathed with confidence or trepidation, satiated or left tense and vaguely unhappy. Nurses familiar with neonates believe that they can often differentiate within the first weeks between babies who are content and those who are fretful in response to their mother's attitudes and handling. Many authorities believe that the mother's tensions are clearly conveyed to the neonate. Still, there are reasons to consider that newborn infants are not unduly sensitive to the manner in which they are handled, and, provided that their essential needs are met, the mother's emotional attitudes are important largely because of the patterns established and their consequences to the continuing mother-child relationship.

Neonates possess an omnipotence that they will never again possess. They but raise their voices

and their needs are served. It is an omnipotence of helplessness; but they are fed, cleaned, cuddled, and kept comfortable. The feelings of undisturbed nirvana-like calm remain dimly within a person, and may serve as a retrogressive goal toward which individuals strive to return as they grow from it into a more demanding and disturbing world. All ill persons have a tendency to regress in order to regain care and protection, and the fetal position adopted by some schizophrenic patients is considered to derive from unconscious and unformed memories of the only period of bliss the patient has known. The neonate's helplessness diminishes gradually and the period blends into the remainder of infancy, but for many months the vital issues will continue to focus upon the parental persons' capacities to provide the total care that the young infant requires.

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Notes

- 1 If the mother contracts German measles early in her pregnancy, the virus can affect the development of the fetus's brain. Marked thyroid or iodine deficiency in the mother can lead to the production of a cretin, a child with deficient thyroid development. Diabetic mothers tend to give birth to unusually large babies. Medication that may not be noxious to the mother may seriously damage the fetus, etc. The course of labor can be influenced by the mother's fears; and a difficult, prolonged labor can require considerable anesthesia that diminishes the neonate's reactivity for several days, thus influencing the baby's start in life, or interfere with the supply of oxygen to the fetus and with breathing after birth, which can lead to damage of the brain, usually, though not always, of a minimal if not insignificant degree (Association for the Aid of Crippled Children, 1964; Corah, et al., 1965).
- 2 There were, however, few, if any, careful observers until Wolff (1966) studied four infants from the moment of delivery through their fifth day of life by continuous observation for sixteen to eighteen hours a day. He brought a new understanding of neonatal behavior by drawing attention to how it varies with the infant's differing states of sleep and wakefulness.
- 3 The importance of this change to understanding sensorimotor development will be considered in the next chapter, in the discussion of Piaget's observations and conceptualizations.
- 4 Aside from such learning, recent evidence shows that the neonate can be conditioned in the first days of life (Connolly and Stratton, 1969), in contrast to earlier evidence to the contrary. Of particular interest is Reuben Kron's (1966) work showing that sucking behavior is amenable to "instrumental" conditioning, and thus suggesting that from the first day the reward of nutriment reinforces and accelerates sucking and, if sucking is unrewarded, the sucking reflex is gradually extinguished. We must, however, note that thumb sucking in older children does not become extinguished, even though it does not bring a nutritional reward.
- 5 Rhythmical crying consists of a cry of perhaps a half to three-quarters of a second followed in turn by a brief silence, an inspiratory whistle, and another brief rest before the next cry begins. As the rest after the cry is shorter than the rest after the inspiration, one

hears a unit as a cry followed by an inspiration rather than vice versa. Rhythmic crying is, at this period of life, accompanied by synchronous kicking.

- 6 Some developmental defect, usually relatively trivial, exists in about one out of every sixteen infants. Some will create difficulties sooner or later and influence the course of personality development. Cardiac anomalies may require surgery during the first months or chronically impede physical development and activity. A prominent birthmark may have influence through parental attitudes and later through provoking self-consciousness in the child. The first weeks of life remain somewhat precarious, for even though infant mortality has been cut almost in half over the past thirty years, the death rate among neonates has declined only slightly. However, much of the danger to life arises because a certain number of babies are born without the essential equipment for survival. It is hoped that genetic counseling and reliable contraception will diminish the number. The properly formed and adequately mature neonate will survive without difficulty in contemporary civilized societies unless something untoward occurs.
- 7 The millions of copies of Benjamin Spock's *Baby and Child Care* sold in many languages attest to the need. In New Zealand the Plunkett Society has specially trained nurses visit and advise every mother weekly at first and then with decreasing frequency until the child enters school—unless the parents specifically decline such help—and it also distributes carefully prepared literature to guide parents in the care of their children. The society also runs four special hospitals to which a mother and baby can be sent if either fails to flourish during the child's infancy.
- 8 Behaviorist psychology, which dominated the scene in the decade preceding World War II, was one of the first major challenges to traditional child-rearing practices, and taught rigidly scheduled feeding and handling and early conditioning of bowel training to inculcate proper character training. A good mother was supposed to squelch her concerns and much of her maternal feelings for the good of the child; many mothers found this unnatural approach difficult, but only the more independent and secure mothers could flout the authorities and accept the guilt of raising their children improperly. Toward the end of the 1930s, a major shift in policy occurred under the growing impact of psychoanalytic teachings. Repression was considered the source of most emotional disturbances, but the advice to avoid unnecessary repressive measures was often misunderstood to mean abandonment of guidance and consistent firmness. Lately, there has been mistrust of scientific guidance, with an emphasis on bountifully supplying "love," often in the form of considerable handling and frequent nursing.
- 9 The movement was started by an English obstetrician, Grantly Dick Read, whose book, *Childbirth Without Fear*, has exerted wide influence upon the practice of obstetrics. Read considered that most of the pain of labor is a product of civilization and that childbirth was simple and relatively painless among primitive peoples. Useful techniques can, upon occasion, derive from faulty assumptions. Indeed, many preliterate peoples fear childbirth, the women often experience considerable pain, and the high maternal and infant mortality rates can lead to reliance upon elaborate rites that may be almost as painful to an observer as to the mother because of their inefficiency.
- 10 Although obstetricians have frequently been idolized by the women whose babies they deliver, in the past few years many women, particularly liberated women, have deeply resented the impersonal attitudes of many obstetricians, and the unfeeling manner in which they examine women, using a cold speculum and often talking to the woman only while examining her perineum; and women have sought out those rare persons—women obstetricians—as well as, increasingly, nurse-midwives.