Born Too Soon:
The Enduring Effects of a Premature Birth on the Psyche

A Hermeneutic Literature Review

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Abstract

Premature babies suffer intrusive and painful medical procedures. They often teeter on the precipice of life and death and are subjected to lengthy separations from their mothers in life-saving, but contact-limiting, incubators. It is unbearable to imagine their experiences of helplessness, terror and dread, as they struggle with physical and emotional pain.

This study uses a hermeneutic literature review process to explore psychoanalytic literature that has clinically and/or conceptually made a connection between premature birth experiences and ongoing implications for the psyche.

This study found that adults who had experienced a premature birth as an infant often appear to have a persistence of unhealed, nonsymbolised, nonverbalised trauma and a self that has creatively adapted to its early environment of deprivation. The psyche appears to be haunted by feelings of overwhelming helplessness, hopelessness, terror and dread. The structure of the psyche can be affected and rendered vulnerable to future traumas. In the face of this difficult early life start, the developing self struggles to depend on others, instead finding alternative ways to gain comfort. Ongoing development of the inner self suffers from the need to over-adapt to the environment, which then impedes the adult capacity to reflect, think and make meaning. These creative adaptations distort the developing psyche and affect the capacity to feel truly alive. Throughout the study, I reflect on my subjectivity and progressive understandings. I use these, alongside my embodied responses, to form my interpretive lens: that premature birth could be understood as an experience of torture.

In our current socio-cultural context, these enduring effects on the psyche appear to go widely unacknowledged as the prevailing narrative appears to be that babies do not have the capacity to remember. I argue that this narrative is able to evolve, and that the provision of a framework to think about the premature baby's experience is needed.

This study contributes to an emerging body of literature on the lasting impacts of birth experiences. The implications of these findings are useful to psychotherapy practitioners and other professionals working with children, adults and families who have been through the experience of a premature birth. It may provide nurses, doctors and medical staff in hospital environments with a different way of understanding their infant patients and help to strengthen the bridge between psychotherapy and the medical world.

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which, to a substantial extent, has been submitted for the award of any other degree or diploma of a university or other institute of higher learning.

Sally Cousins

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Chapter One: Introduction

"We do
such dreadful
things to them,
I just hope
that they forget." [1]

In Aotearoa New Zealand, an average of 7.5% of babies are born prematurely (Ministry of Health, 2020); that is over 5,000 babies every year (The Neonatal Trust, 2021). Over the last 20 years, best care practices and breakthroughs in medical treatments in high-income countries have helped many more premature babies at even younger gestational ages to survive their births (Glass et al., 2015). The increased survival rate is cause for celebration but there are a growing number of babies, children and adults who have struggled through their own premature birth and its problematic early life experiences.

In the following paragraphs I provide some context for the research topic. I outline intrusive medical procedures premature babies endure to help them stay alive and the impact of separation from their mothers in wards and incubators. I reflect on the difficulty of parents and medical staff in witnessing these experiences.

Complications, during and after birth, are often life-threatening and require invasive medical intervention. Often, the lungs of premature babies at birth have yet to fully mature. This means that they can get into respiratory distress and need oxygen therapy to survive (Crider, 2020). 5 – 10% of premature babies may even need total physical resuscitation at birth (Lawn et al., 2013). Premature babies tend to have low birth weight and body fat impeding their ability to maintain a constant body temperature (Crider, 2020). They are often placed in temperature-controlled incubators or under plastic tents and heat lamps (Boyer & Sorenson, 1999). Their skin surface is thinner, more sensitive to pain and more vulnerable to infection (Blessing, 2006). They are more at risk of dying from severe infection or neonatal sepsis (Lawn et al, 2013). As the sucking and swallowing reflex does not establish until 34 weeks, they sometimes have difficulties feeding (Lawn et al., 2013). They are often fed through a tube inserted in their nose to their stomach, a traumatising procedure that causes their heartrate and oxygen levels to drop (Boyer & Sorenson, 1999) and can be life threatening if inhaled into their airways or lungs (Lawn et al., 2013). Premature infants are often placed in specialist hospital

[1] A reflection from a doctor on the Neonatal Intensive Care Unit (Cohen, 2003, p. 10) rearranged into a fusion poem as described by Green et al. (2021) in an article on hermeneutic meaning-making and the richness of poetic inquiry.

units, which although life-promoting, have been described as unnatural, stressful and highly medicalised (Cantle, 2013). The ward can feel overstimulating, crowded, noisy, and light; a baby's sleep rhythms might be interrupted by doctors administering tests and interventions (Cohen, 2003). Instead of feeling contained and held, premature babies usually have an assortment of wires and leads attached to and into their bodies to support breathing, feeding, monitoring and the giving of medicine (Cohen, 2003). Figure 1 is an image of a premature baby in an incubator, showing the collection of wires and medical apparatus penetrating the baby's body. Boyer and Sorenson (1999) describe the wards and treatments as a series of boundary violations; of the baby's body and senses; of the family unit; on the ultimate and terrifying boundary between life and death. Recently there has been growing concern over the emotional impacts and long-term effects of premature birth experiences on the baby (Blessing, 2006). Vanier (2015) argues that alongside the medical interventions, there is a critical need for the co-resuscitation of the baby's desire to live.

Figure 1

Premature Baby in an Incubator

Note. From dreamstime, by Mb2006, n.d. (https://www.dreamstime.com/image-premature-baby-incubator-image123548172). Reprinted with permission.

From a psychoanalytic perspective, the separation of premature babies in specialist units away from their mothers is considered to have an impact on the baby. It has been suggested that a baby might miss out on being called into existence, sometimes falling into a state of non-being (Eekhoff, 2013). During procedures, a baby's raw physical and emotional pain appears intensified by the

absence of their mother's body, voice, gaze and mind to help them cope and make sense of themselves and their experiences (Cohen, 2003). Early coping defences against this pain are thought to be drawn upon by the baby, but when relied upon too often affect a baby's growing sense of self (Waddell, 2002). Sadly, many of these premature birth experiences can feel so distressing that they become unseen in the hospital setting. Blessing (2006) suggests that the terror and primitive anxieties evoked in witnessing a neonate's painful life or death struggle can feel unbearable for parents and hospital staff, eliciting defences that encourage detachment and turning away (Turp, 2012). Cantle (2013) suggests that a mother may be responding to her own feelings of shock, loss, failure and trauma, which can inhibit her sensitivity to her baby's emotional experience and capacity to bear and relieve her baby's distress (Cantle, 2013). Fortunately, mothers and babies are now widely encouraged to engage in direct skin-to-skin contact, or Kangaroo Care. Originating from Columbia as an alternative method of treatment due to the unavailability of incubators, it has been found to reduce infant mortality and responses to pain, and promote satisfaction and attachment in the mother-infant relationship (Dooley, 2016). A mother may sometimes need help and encouragement from hospital staff to feel competent with her new tiny and fragile baby (Vanier, 2017) and many wards now employ psychotherapists and psychologists (Cantle, 2013; Castro, 2011; Cohen, 2003; McFadyen, 1995; Negri, 1994; Steinberg & Patterson, 2017; Vanier, 2015) to help interpret the baby's subjective experience and mediate the relationships between babies, parents, nurses and doctors.

My Motivation for the Research

I became interested in this topic as I wanted to better understand the effects of my own premature birth experience. I was born in England in the 1970s, six weeks before my due date, after an urgent induction. As I was delivered, the umbilical cord was wrapped tightly twice around my neck and I was unable to breathe on my own. I was intubated for breathing and feeding, underwent frequent medical tests and spent my first weeks in an incubator, separated from my mother. Several years ago, I began to explore my premature birth in the personal psychotherapy that accompanied my clinical training. Although I have always known about my premature birth, I had never before attached any meaning to the experience. Around the same time, I attended a class which nudged my academic interest in the topic. However, I found myself unable to clearly articulate the topic and abandoned the idea of exploring it. At that time, I struggled with feelings of disconnection and detachment from my neonate self. Professionally, I knew it would be important for me to own my experience so that I could help clients with their disowned experiences. As I started thinking about a topic for this dissertation, I wondered if I could resuscitate the neglected and previously discarded area of premature birth. My personal and academic experiences motivated this research. It felt as if I had been 'addressed' by the topic (Moules, 2002); the subject was already at play and this research was bringing it to life.

Preliminary Literature Review

Premature birth has been linked in the short-term to increased rates of cerebral palsy (Vincer et al., 2014) and in the long-term, to disorders affecting an adult's major organs, such as the heart, lungs and kidneys (Crump, 2020). Research has linked premature babies with poor social behaviour, emotional regulation, capacity for attention (Arpi & Ferrari, 2013), cognitive difficulties, ADHD (Bhutta et al., 2002) and Autistic Spectrum Disorder diagnoses (Kuzniewicz et al., 2014). Extremely premature babies may face problems with sleep disturbances, disordered eating, heightened anxieties and phobias (Vanier, 2015). Specifically, a baby's exposure to pain-related and stressful procedures in the Neonatal Intensive Care Unit (NICU) have been found to contribute to increased cortisol levels and heightened stress responses that persist well into childhood (Brummelte et al., 2015). In Aotearoa New Zealand, there is a longitudinal study currently running that aims to measure the long-term effects of preterm birth on the brain and behavioural development in 17-year-olds (University of Otago, n.d).

Qualitative research has explored the experiences of the parents of premature babies. Studies have examined parental experiences in the hospital (Arnold et al., 2013; Russell et al., 2014; Steinberg & Patterson, 2017; Steyn et al., 2017), maternal responses to separation in the NICU (Nyström & Axelsson, 2006) and maternal bonding behaviours across the infant's first few months (Coppola et al., 2007; Hoffenkamp, et al., 2012; Korja, et al., 2012; Lubetzky & Gilat, 2002). Other qualitative research has focused on the emotional lives and experiences of premature babies as they develop into children and adults. In 2005, a study reviewed the literature on childhood attachment styles of formerly premature babies (Wilkinson, 2005). In 2015, a case study of a child who had been born prematurely was used to develop the concept of an 'Incubator Psyche' (MacDonald, 2015). Although not related specifically to premature birth, some qualitative studies are interested in exploring the enduring effects of a caesarean delivery on an adult's personality (Milliken, 2007; Verdult, 2009), indicating a possible emerging interest in the long-term effects of increasingly common experiences in early infancy.

The majority of existing research on the effects of premature birth take a quantitative approach, demonstrating associations between preterm birth and physical and mental health outcomes. There are some qualitative studies, however they focus mainly on the parents' experiences of their infant's premature birth. This firstly suggests a need for more qualitative research that provides rich accounts of the human experience. Secondly, there is a paucity of research exploring the baby's subjective experience, highlighting a gap in the literature, and supporting the relevance and benefit of this study. There appears to be much that remains unknown, not richly understood and yet to be revealed. In this dissertation I am interested in understanding how the psyche of the adult who has been a premature baby may be affected by their experience of their premature birth. Although many

adverse outcomes have been observed, Glass et al. (2015) note that many premature babies go on to develop without any diagnosed physical or mental health challenges. In this dissertation I am interested in understanding possible enduring traces on the psyche that might be more difficult to measurably observe or to group into diagnostic criteria. I would like to understand if more meaning can be made from the longer term implications of a premature birth experience.

Research Question

Evoked by a personal interest and an initial engagement with the topic which notices a gap in understanding, this study asks: "What are the enduring effects of a premature birth experience on the psyche?"

Aim, Scope and Significance

The literature indicates that premature babies suffer physically and emotionally painful interventions that keep them alive. There is a lack of qualitative research on the consequences of these experiences. In this study, I aim to develop a deeper understanding of the enduring effects of premature birth experiences on the psyche. I will be taking a psychoanalytic approach and will review psychoanalytic literature to explore my research question. I intend to review texts that clinically and conceptually explore a connection between premature birth and implications on the psyche. I will focus on journal articles found in the Psychoanalytic Electronic Publishing (PEP) database and am most interested in articles that discuss effects that are not attributed to a diagnosed physical or psychological disorder. I hope to encourage new thinking on the phenomenon (Smythe & Spence, 2012). Against a background of little qualitative research on the research topic, this study provides an opportunity to usefully contribute to the existing knowledge base.

Defining Premature Birth

The World Health Organisation (WHO) (2018) defines premature birth as "babies born alive before 37 weeks of pregnancy are completed". The WHO proposes further sub-categories based on gestational age, ranging from "extremely preterm (less than 28 weeks) to very preterm (28 to 32 weeks) to moderate to late preterm (32 to 37 weeks)" (World Health Organisation, 2018). In Aotearoa New Zealand, doctors consider premature babies born from 23 gestational weeks viable and eligible for resuscitative interventions (Dawes et al., 2020). For the purposes of this research, I will use the term "premature birth" to describe all alive babies born before 37 gestation weeks and will not make a distinction between categories of prematurity.

Defining Psyche

The Cambridge Dictionary defines psyche as "the mind; your deepest feelings and attitudes" (Cambridge University Press, n.d.). In psychoanalytic theory it includes both conscious and

unconscious elements (Merriam-Webster, n.d.). Psychoanalytic understandings of the conscious and unconscious mind differ in their influences. These models range from an emphasis on the intrapsychic to the interpersonal or a mix of both, and can be conceived as structural functions through to representations of self, object and relationships (Bateman & Holmes, 1995). The British paediatrician and psychoanalyst Donald Winnicott suggested that the psyche develops from bodily experience in infancy (Quatman, 2015), describing the psyche as "the imaginative elaboration of somatic parts, feelings and functions, that is, of physical aliveness" (Winnicott, 1954, p. 202). In health, it has been proposed that the psyche links up all parts of the personality to retain feelings of integration (Kalsched, 1996). In trauma, the psyche protects itself by de-linking, using defence mechanisms like splitting or dissociation to survive (Kalsched, 1996). In this study, I am interested in understanding ways the traumatic experiences of a premature birth may impact the structure of the psyche, a person's conscious and unconscious feelings, thoughts, experience of self and relationships.

Chapter Summary

In this chapter I have introduced the topic of premature birth, including a discussion on my personal and academic motivations for the study. I have noted a need for more qualitative research and formulated a research question.

Overview of the Following Chapters

In Chapter Two I will describe the methodology and method used in the research. In Chapters Three and Four I will show the findings. In Chapter Five, I will conclude with a discussion on the findings and an exploration of the strengths, limitations and implications of this study.

Chapter Two: Methodology and Method

I chose a hermeneutic methodology and literature review method to answer the research question: "What are the enduring effects of a premature birth experience on the psyche?". In this chapter, I discuss the hermeneutic methodology, its philosophical assumptions and my reasons for choosing this approach. I reflect on the pre-understandings that I bring to the study, before describing the hermeneutic literature review method and the processes that I followed in my research. Lastly, in this chapter I provide a consideration of validity and quality in relation to conducting this research.

Hermeneutic Methodology

The philosophical work of Hans-Georg Gadamer is concerned with the theory of interpretation and understanding (Alsaigh & Coyne, 2021; Gadamer, 2013; Higgs et al., 2012; Moules, 2002; Smythe & Spence, 2012). The hermeneutic methodology sits within the interpretive paradigm, which has a defined set of ontological and epistemological assumptions. The interpretive paradigm assumes that research is not trying to uncover one single reality or truth, it believes that reality is multiple and differs from person to person (Davies & Fisher, 2018). The interpretive paradigm holds a subjectivist epistemology that assumes knowledge and meaning is made from the researcher's thoughts and processing of the data (Kivunja & Kuyini, 2017). In a hermeneutic approach, subjectivity is appreciated and integrated into the research process (Fleming et al., 2003).

A Gadamerian hermeneutic methodology needs to further consider the notions of pre-understandings, the hermeneutic circle and fusion of horizons (Alsaigh & Coyne, 2021). Pre-understandings are the personal knowledge, experiences and histories that already exist within and relate to a topic, consciously or unconsciously shaping your perspective (Smythe & Spence, 2012). In a broad sense, they help us make sense of the world (Whitehead, 2004) and make understanding possible (Fleming et al., 2003). As they have the capacity to highly influence the research process, they need to be reflected upon and considered at the beginning of and throughout the research process (Maxwell et al., 2020; Whitehead, 2004). Failure to do so can lead to limitations in understanding the familiar or unfamiliar of the data (Alsaigh & Coyne, 2021), or shape research findings in advance (Smythe & Spence, 2012). Later in this chapter, I will discuss my professional, personal and socio-cultural pre-understandings that accompanied me into the study. The hermeneutic circle describes the movement between the whole and the parts (Whitehead, 2004). My pre-understandings that relate to the topic form the initial horizon, the "whole" (Boell & Cecez-Kecmanovic, 2014). Each article in the literature review forms a "part", which then grows my understanding of the "whole" (Boell & Cecez-Kecmanovic, 2014). To gain an understanding of each text, researchers suggest developing a dialogue with the text, which includes an openness to receive (Alsaigh & Coyne, 2021; Smythe 2019).

Immersion in the material can also include emotional responses to the text, which are then integrated into the research (Fleming et al., 2003; Schuster, 2013). The hermeneutic circle involves continuous reflection on the parts and the whole until understanding emerges (Whitehead, 2004). A fusion of horizons is in the interaction of pre-understandings with the meaning of the texts, a connection between the familiar and the unfamiliar (Alsaigh & Coyne, 2021). However, it must be noted that the nature of a fusion of horizons is always temporal; further iterations of the hermeneutic circle will produce fresh interpretations (Whitehead, 2004), as there is always more to be understood (Crowther & Thomson, 2020; Smythe, 2019).

Through the research process, I am interested in gaining a deeper understanding of the enduring effects of a premature birth on the psyche. Although the literature will be synthesised into findings, they are not an objective re-presentation of a singular truth, but an interpretation of the texts that have emerged through my attentiveness and attunement to the literature (Smythe, 2019). The interpretations within this study are therefore particular to me, shaped by my own experiences and an expression of my aesthetic experience (Gadamer, 2013) with the text.

Suitability of the Hermeneutic Methodology

A hermeneutic approach is concerned with the human world (Higgs et al., 2012) and seeking a deeper meaning on a topic (Alsaigh & Coyne, 2021; Smythe 2019), making it well suited to understanding the enduring effects of premature birth on the psyche. The research question is broad and open-ended, encouraging an expansive exploration of the topic, whilst helping to maintain an orientation to the subject, rendering the question congruent with the hermeneutic endeavour (Alsaigh & Coyne, 2021; Fleming et al., 2003).

There is good alignment with hermeneutic research and my background as a psychotherapist, both in practice and in its sharing of ontological and epistemological assumptions. Bateman and Holmes (1995) note that interpretations and meaning making are the essence of clinical practice. Gadamer's philosophical ideas have been explicitly applied in Donnel Stern's relational psychoanalytic theory of the mind and practice. Stern (2010) argues that in therapy there is no singular experiential truth to uncover, and the therapist's subjectivity cannot be ignored. A client's pre-understandings, formed by their experiences and history, allow individuals to make shortcuts in understanding their world, but this can sometimes limit their perspective and experiences (Stern, 2003). During therapy and through dialogue, an understanding of the client's self is gained with the ultimate goal of the client and therapist reaching a fusion of horizons (Stern, 2010). There appears to be a good fit between my professional discipline of psychotherapy and hermeneutics, with a shared understanding of the nature of reality and gaining knowledge, and a direct application of Gadamer's key concepts to the therapy process.

As an alternative, I considered interviewing adults who had experienced a premature birth and conducting an interpretive phenomenological analysis. One of the challenges of this approach was in gaining access to the human lived experiences in the data collection phase, as by nature premature birth experiences are preverbal and most often pre-reflective. Various methods were considered but for the purposes of this study, within the constraints of the available time and resources, and with the decision to examine literature, a phenomenological approach became inappropriate.

A hermeneutic approach was ultimately chosen as there is good alignment with the research topic, question and my background as a psychotherapist, reviewing psychoanalytic literature. I felt there was a benefit in gaining a deeper understanding of the ways my professional discipline makes sense of the topic, especially within the context of little existing qualitative research.

My Pre-Understandings

Here I explore my pre-understandings, making conscious some of the ways my history may influence the research process (Smythe & Spence, 2012). My pre-understandings were 'provoked' (Fleming et al., 2003; Maxwell et al., 2020) through dialogues with a colleague, a friend and journaling. They demonstrate my horizons at the beginning of the research journey and are reflected on throughout the study as my understandings deepened and developed (Maxwell et al., 2020). My pre-understandings are influenced by my professional training, personal experience and the broader socio-cultural context. Identifying these influences helped to consider my position on the research topic and enhances the validity of the study (Whitehead, 2004).

Firstly, I will consider the influences of my professional training. These are critical as they made understanding the topic and psychoanalytic literature possible (Fleming et al., 2003). I am a psychotherapist, writing this dissertation at the end of my clinical training in psychodynamic psychotherapy. My immersion in this discipline and practice forms part of the lens through which I understand and interpret the literature. Although my training has prompted me towards psychoanalytic thinkers like Winnicott, Bowlby and Klein who might consider the impact of premature birth on the developing psyche, the topic was not taught as part of the curriculum. I felt open and curious about what I might find.

I expected my own personal experiences to have an impact on the study, consciously and unconsciously. Early on in the project, I became aware of a nervousness about and keenness to validate my own experiences. I wrote down and captured these experiences and connections, in an effort to keep my engagement with the reading as open as possible (Smythe & Spence, 2012). I noticed that I wanted to consider only the baby's experience, rather than the mother's experience or the mother-infant relationship. This may have been a way to start connecting and attaching to my neonate self which at the start of the research felt somewhat abstract.

In consideration of the socio-cultural setting, it appeared that the dominant socio-cultural narrative relating to premature births in Aotearoa New Zealand is that babies do not have the capacity to remember. I felt confused by this, as I felt that the baby's experience was in some way being overlooked. At the same time, this perhaps mirrored my initial lack of connection with my neonate self and the lack of personal meaning I had made from the experience. As I thought about the audience for my dissertation at the beginning of the project, I felt most inhibited by the imagined non-audience of the disinterested (O'Connor, 2017), that to me is a representation of this mainstream part of society.

These pre-understandings pointed to my position (Maxwell et al., 2020) as an "insider" to the research topic of premature birth. Reflecting on my professional training and personal experiences allowed me to realise that my stance included the belief that premature birth experiences of near death, pain and separation from the caregiver are likely to have enduring effects on the psyche that may be conscious or unconscious. This belief appeared to be in conflict with the current socio-cultural narrative that babies cannot remember. The process of provoking my pre-understandings illuminated the desire in me for this research to give voice to the baby, bringing the traces of their experiences to the fore. These pre-understandings formed my initial narrow horizon, which I anticipated would widen and extend as I engaged with the psychoanalytic texts, and developed a deeper understanding, towards a fusion of horizons (Boell & Cecez-Kecmanovic, 2014). It occurred to me as I tried to capture a summary of my pre-understandings concisely, there appeared to be a lack of meaning made of the premature birth experience, both personally and in the dominant socio-cultural setting of Aotearoa New Zealand. Perhaps the aim of my research question was an unconscious desire to make meaning and learn from my experience. By explicitly recording my pre-understandings and horizon, I aimed to establish the beginnings of an audit trail that allows readers to follow my journey of interpretation, enhancing the dependability and the broader trustworthiness of the study (Ryan et al., 2007; Whitehead, 2004).

I will now describe the hermeneutic literature review process that I followed, including some of the challenges I faced.

Hermeneutic Literature Review Method

To gain an understanding of my research question, I followed the hermeneutic literature review method developed by Boell and Cecez-Kecmanovic (2010, 2014). This method encourages a non-linear, iterative understanding of the topic to develop and is congruent with the Gadamerian concepts of pre-understandings, the hermeneutic circle and fusion of horizons (Boell and Cecez-Kecmanovic, 2014). Through the process, I moved through two hermeneutic circles of "Search and Acquisition" and "Analysis and Interpretation" (Boell and Cecez-Kecmanovic, 2014). I read and selected relevant literature and then engaged with the texts to develop my understanding. During the

process, I often felt stuck. Schuster's (2013) suggestion to lean on my embodied experience was essential in creating space and moving my pre-reflective reading into a critical interpretation of the texts. Crafting stories (Crowther et al., 2017; Crowther & Thomson, 2020; Smythe & Spence, 2020) helped to move my assessment of the body of texts from a descriptive synthesis to a deeper interpretation of the material.

Although some have argued that strictly following a method goes against Gadamer's intentions and can affect the quality of findings (Smythe, 2019), I agree with those who have reasoned that as a novice researcher following a process was reassuring (Alsaigh & Coyne, 2021; Fleming et al., 2003). Further, by maintaining an open-ness, gathering an embodied knowing of the "wholeness" of the research and attending to the journey, (Smythe, 2019), I believe this study is congruent to the spirit of a hermeneutic pursuit.

I will now describe in more detail the method I followed to gain a deeper understanding of the body of psychoanalytic texts relating to my research question. In the paragraphs below, I describe these circles and processes separately, however in reality I moved between them.

Entering the Hermeneutic Circle

I entered the hermeneutic circle with a research question motivated by personal experience and an academic curiosity. I decided to target psychoanalytic literature found in the digital psychoanalytic database, PEP, a vast online library of high quality psychoanalytic articles. My initial engagement with the psychotherapy literature followed a serendipitous meeting with a colleague who forwarded me a few recent relevant journal articles that explored clinical material with psychotherapy clients who had experienced a premature birth. I used my pre-understandings to make sense of each piece of literature. I then gained a preliminary understanding of some concepts and authors that appeared useful in making sense of the effects of a premature birth experience on the psyche.

Search and Acquisition Circle

As I moved through the search and acquisition circle, I made use of the snowballing technique (Boell & Cecez-Kecmanovic, 2014), utilising the reference lists of read articles to identify other relevant articles that had already been published. One of the initial articles (MacDonald, 2015) supplied an overview of the literature which was helpful in gaining a summary of psychoanalytic writing on the topic (Boell & Cecez-Kecmanovic, 2010) and provided me with an additional search term "incubator". I used key search terms of "premature birth" and "incubator" in the PEP database, which returned 370 and 270 papers each, where the terms were used. I sorted and ordered the papers by year and scanned the titles and abstracts to screen for relevance. I dismissed articles that used the key terms as metaphors for unrelated phenomena, focused on the parents' experience, or mentioned premature birth experiences only in passing, not as key and formative experiences for discussion. I

chose articles that clearly linked client presentations to their own premature births. I wrote notes in the margins of readings, including my personal responses to the material, which captured my developing understanding for reflection as I re-entered the circles in subsequent iterations.

I attended an online conference that included sessions on primitive mental states and came across books richly and tenderly written by child psychotherapists working in NICU environments (Cohen, 2003; McFadyen, 1995; Negri, 1994; Vanier 2013). These provided me with an experience-near understanding of the context that premature babies are born into and widened my professional horizon. It alerted me to the difficult emotions this topic evokes in others (and in me) and the compulsion to defend ourselves against these painful primitive terrors.

One of the references led me to a website and learning centre for the Association for Prenatal and Perinatal Psychology and Health (APPPAH), that specialises in birth psychology and early human development. Here I found further resources and relevant journal articles that I acquired. An article by American psychiatrist Thomas Verny (1999) captured my emerging frustration and disbelief at society's blindness to infant traumatic pain. He questioned the way we gather new knowledge, through science or intuition, articulated the resistance towards perinatal and prenatal psychology and likened it to the difficulty in facing the terror of the climate crisis (Verny, 1999). I connected to a strong, urgent and angry need to offer a voice for babies who have been born too soon. How could society remain blind to our babies' experiences? At the same time, I began to sense a creeping doubt in the credibility of what I was reading, as I attempted to tackle my internalised mainstream narrative that babies do not remember.

As I began to identify key authors on the topic, I started to read their original writings chronologically, which led me to others who have built on their concepts. Although this was critical for my understanding, I noticed my focus moved away from the research question. The search circle began to get wide, confusing and overwhelming, indicating that I needed to begin the second circle of analysis and interpretation (Boell & Cecez-Kecmanovic, 2014). I selected 19 articles for a more in-depth understanding, however I felt unable to engage. A block had emerged in response to the material I was exploring (O'Connor, 2017). I had perhaps been experiencing the immediacy of my feelings (Schuster, 2013) and wanting to put them to the side. By neglecting them they were inhibiting my capacity to engage further, discouraging me from encountering the text in a critical way (Schuster, 2013).

Creating Space

To evolve into critical thinking, Schuster (2013) encourages creating space on the hermeneutic journey between proximity and distance of feelings. I needed to reflect and understand what was 'going on' through the research process (Koch & Harrington, 1998). To gain closeness to my emotional responses to the texts, I re-visited the personal responses and notes I had written on

articles. Initially, I had felt excited and validated to read that some of my own experiences have been conceptualised by others. I had also noticed a resistance to experiences that did not feel like my own, the other-ness. As I read more about the highly stressful environment that premature babies are born into, I felt an identification with these babies and angry that our experiences did not appear to be widely acknowledged. I began to dream about babies being born into shockingly unanticipated fraught situations. I started feeling panic and overwhelm at the helplessness, dependency, terror and vulnerability of premature birth experiences. I felt a struggle between the life and death of this project. A large part of me wanted to give up and surrender to my feelings of helplessness. I felt as if I was searching for something to latch on to, to provide structure and soothing. Trusting the process (Smythe, 2019) seemed impossibly terrifying.

Analysis and Interpretation Circle

As I entered the second hermeneutic circle, I immersed myself in each "part" (the selected article) to gain an understanding of the "whole" of each text (Alsaigh & Coyne, 2021). I taped a big piece of paper with my research question to the wall in front of my computer to continually re-orient me to my focus (Smythe 2019). I created a system for mapping & classifying the ideas within each text by concept (Boell & Cecez-Kecmanovic, 2014) in excel (please see Appendix A for a representation of this system). The 19 journal articles from the PEP database had been published between 1989 and 2021, with the majority (14) written by female psychotherapists from the UK or the USA. I read in mostly chronological order to understand if the thinking on premature births was building within the psychoanalytic discipline. The excel table allowed me to record my understanding of the whole and parts of each text, the authors cited and concepts applied, the personal feelings the articles evoked in me, and the "other-ness" I was encountering in each article, in an effort to remain open to the unfamiliar.

As I read, analysed and classified each article, I began to make links between the articles "the parts", and noticed my "whole" understanding of the body of literature evolving (Boell & Cecez-Kecmanovic, 2014). I noticed some articles discussed similar enduring effects on the psyche but used different conceptual frameworks, deriving from different psychoanalytic thinkers. This extended my perspective on the unfamiliar. Some authors talked about an effect that had not been thoroughly conceptualised in their article but the effect had been conceptualised in another. I began reading with a different attunement as my understanding widened (Smythe & Spence, 2012). I noticed that some authors appeared to write in an experience-near or experience–far way, evoking sadness, panic, relief, excitement or a detachment and tendency to feel distracted. I noticed that I began to feel less overwhelmed in subsequent readings than in the initial orientational reading and as I made room for my difficult feelings. As I delved deeper into the psychotherapy literature, getting a foothold into theory and concepts, I found that it was increasingly providing a holding function (Almond, 2003) for

me. I felt that I was moving from needing something to latch on to and that I was beginning to understand the research introjectively (Waddell, 2002).

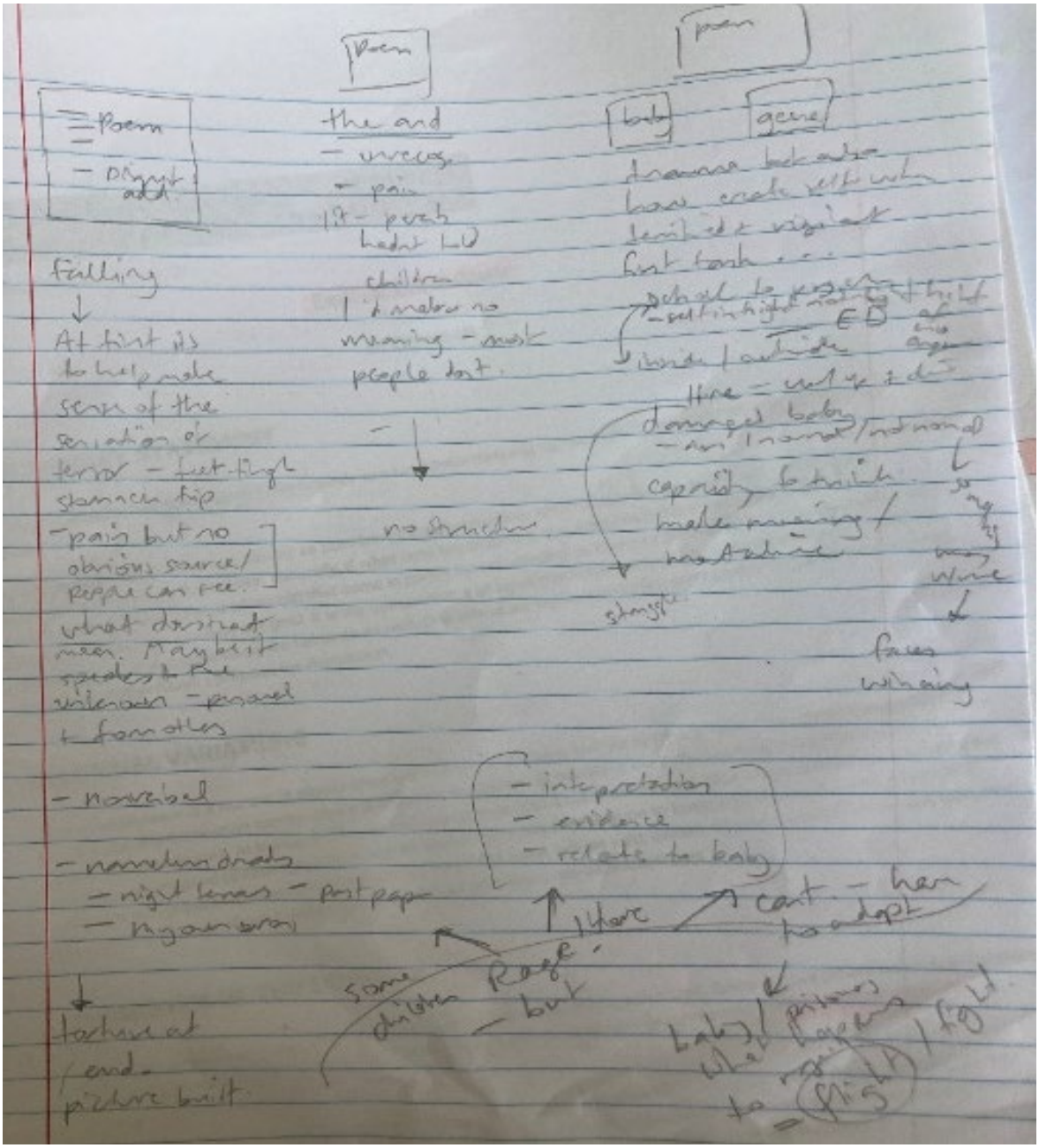
I wrote down enduring effects from my excel sheet onto post it notes and identified themes clustered across the whole body of literature. I related the themes to three specific premature birth experiences of pain, separation and the struggle between life and death. I then re-organised the effects into intrapersonal and interpersonal as I began to synthesise the material and make meaning. In the first draft of my findings I wrote descriptively about the enduring effects on the psyche. I was attracted to effects that had been most frequently written about in the articles and felt under pressure to include every effect that I had noticed, but then realised that this way of writing would stop new hidden insights emerging (Crowther & Thomson, 2020; McCaffrey et al., 2022).

Working with the Data

I needed to find ways to show my interpretation of the effects, rather than 'telling' with evidence (Smythe, 2011), moving from a pure description to an interpretive leap (Crowther & Thomson, 2020). I began to craft stories of meaning from the articles that allowed my interpretations to deepen (Crowther et al., 2017) and encouraged a dwelling in the material (Smythe, 2011). Trusting the process and my emerging understanding became exciting (Smythe, 2019) as I waited for answers in my dialogue with the literature to reveal (Crowther et al., 2014). This often happened away from the computer, in the car, as I was doing the dishes or trying to go to sleep. Figure 2 shows some of the thoughts circling before I tried to go to sleep one night as I was immersed in trying to make meaning across the whole. I talked with my husband, colleagues, my project and clinical supervisor and my therapist. I took advice from Smythe and Spence (2020) and wrote from different locations in my house, which refreshed and focused my thinking.

Figure 2

My Emerging Interpretations



Leaving the Hermeneutic Circle

Whitehead (2004) suggests that the hermeneutic process ends when a temporal understanding is gained. With the acknowledgement that there would always be more meaning to be revealed, I decided to leave the hermeneutic circle when an interpretation emerged from the interaction of my pre-understandings and the literature.

In this section, I have summarized the hermeneutic methods that I followed to gain an understanding of the texts. These included the need to create space for my feelings and working with the data to find understanding. I will now reflect on the validity of my research.

Enhancing the Quality of this Research

Yardley (2008) suggests four key dimensions that are useful in evaluating the validity of research: sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance. In Chapter One, I displayed sensitivity to context by outlining the premature birth experience and providing a preliminary literature review on existing research findings. In addition, my attendance at the online conference helped to develop a deeper professional sensitivity to the context. In Chapters Three and Four, I demonstrate sensitivity to the data, allowing the meanings from the literature to emerge without a pre-conceived idea of the themes (Yardley, 2017). My commitment to the research topic is demonstrated by my immersion over the last year in the literature and my personal and professional motivation to understand the topic which was awakened several years ago. In a hermeneutic project, it can be a challenge to show a standard measure of rigour as by nature it does not aim for replication or generalisation (Crowther et al., 2017; Crowther & Thomson, 2020). However, in order to establish rigour that is in alignment with the philosophical assumptions of a hermeneutic methodology, I have paid attention to and been reflexive on the social and cultural influences that have accompanied me into the study (Crowther & Thomson, 2020). I have reflected throughout the research process, in the hope that readers can follow my journey of interpretation (Crowther et al., 2017; Crowther & Thomson, 2020; Koch & Harrington, 1998; Whitehead, 2004). By offering a detailed account of my data collection and analysis methods, including my mapping system and way of working with the data, I aim to demonstrate transparency and congruence with the methodological approach. I am hopeful that the structure and organisation of my study is helpful in navigating readers through the study, illustrating coherence (Crowther & Thomson, 2020). In Chapter One, I suggested that there is lack of qualitative research on the topic, and in Chapter Five I will outline ways that this research makes an important contribution to the area of premature births and is relevant to clinical professional practice and training.

Chapter Summary

This chapter has described the hermeneutic methodology and its philosophical assumptions. I have provided a detailed account of the process that I followed for this study which, I hope, enhances its level of transparency and lays the foundations for the findings that follow. In the following two chapters, I will present the findings from my literature review.

Chapter Three: Unhealed Trauma

In Chapter One, I described some of the physically and emotionally traumatising experiences premature babies endure in their struggle to stay alive. In this chapter, I discuss my findings from the literature that relate to this early trauma and will argue that this trauma remains unhealed. I will begin now by introducing the interpretive lens through which I have made meaning of the data.

My Interpretive Lens

Torture

Helpless, Hopeless
Terror
Intense, struggle
Disgust
Endless torture
Alone and overwhelmed

Released
But how to heal
How to tell (when I don't even know it)
How to make sense (when no one has made sense of it)
Perhaps no one cares

I wrote this poem during my immersion in the literature. The words intruded for several nights as I awoke in dream states. Circling in my mind, fragmented and raw, calling out to me in a most disturbing way. During the day, these words were accompanied by an intense somatic sensation of my throat and chest infused with burning, as if I had been vomiting in disgust. I suddenly recalled myself as a nine year old at Madame Tussauds in London, clinging to the banister of the stairs, tears pouring down my face in terror as my family encouraged me to go with them into the Chamber of Horrors[2]. Looking back, it was as if my body was remembering something that my conscious mind could not.

[2]The Chamber of Horrors was an exhibition in Madame Tussauds' waxwork museum that showcased notorious murderers, instruments of torture and included real actors to intensify the horror with screams of agony. The exhibition is now closed.

I will now discuss the findings relating to trauma. I will also show my journey of thinking that led to my interpretation of premature birth as an experience of torture.

Falling Forever: An Endless Torturous Agony

It was striking and distressing to observe many writers commenting on witnessing intense states of helplessness, hopelessness, terror and dread in clients who had a history of premature birth (Alhanati, 2004; Blessing, 2006; Eekhoff, 2013; Emanuel, 1996; Gurevich, 2014; Kupfermann, 2005; Lunn & Pedersen, 2016; Maiello, 2012; Mikardo, 1995; Reiner, 2006; Turp, 2012; Urwin, 1998; Wooldridge, 2018). Some writers made sense of these states by linking their client's early infant trauma with Winnicott's concept of the 'Fear of Breakdown'.

Winnicott (1960) proposed that in the earliest stage of development, a baby is in a state of absolute dependence on the mother. To develop emotionally and establish a sense of self, a baby in this state needs maternal care that is 'holding' (Winnicott, 1960). This is characterised as a reliable and empathic meeting of a baby's physical needs and protection from physical harm (Winnicott, 1960). But how can this type of reliable and attuned care be possible for a premature baby who is separated for long periods from the mother? This lack of care has been understood as a failure in the facilitating environment leading to a breakdown in the self (Winnicott, 1974). Winnicott theorised some clients show this fear of breakdown that "has already been experienced" (Winnicott, 1974, p. 104), but it was before a sense of self was able to be established and the ego developed enough to integrate the experience. The original agony "cannot get into the past tense" (Winnicott, 1974, p. 105), instead remaining an unbearable fear that haunts the future. Out of several possible agonies listed by Winnicott, the agony of falling forever appeared to resonate with writers making clinical meaning of their client's enduring distress. These Winnicottian ideas were used to connect a premature baby's isolation in the incubator to a lack of adequate holding by the mother and then to the enduring effects of this unbearable agony. A haunting, endless, helpless terror in the psyche.

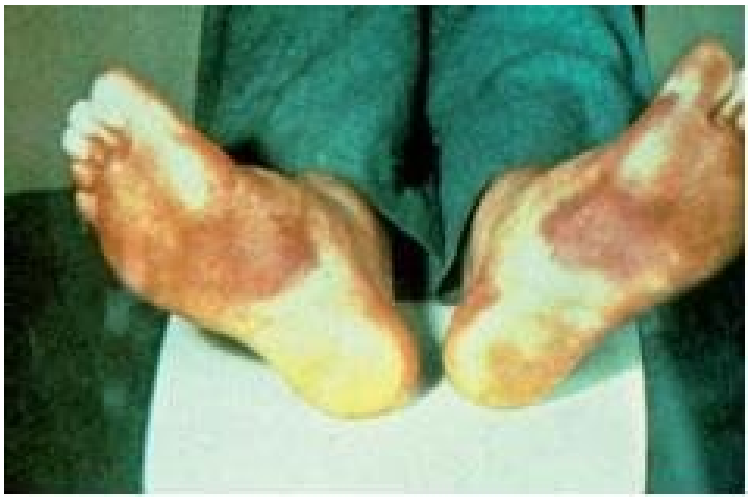
Wooldridge (2018) discussed his client's frequent somatic dread of falling forever and related this to her early weeks fighting for her life alone in an incubator. Kupfermann (2005) similarly connected her client's terror of falling though space to the bewildering atmosphere in the incubator. Gurevich (2014) described the incubator and absence of the mother as a "black hole into which she would fall and fall" (p.319). Lunn and Pedersen (2016) described a client's terrifying feeling state of falling forever into a formless hole in more detail. At times of change or relational insecurity, terror haunted her but made no sense (Lunn & Pedersen, 2016). The client compared her confusion to the torture of falanga, a brutal torture delivered to the soles of the feet that causes chronic pain but leaves no visible trace (Lunn & Pedersen, 2016). This image came to be a representation of her experience as a premature baby, without good-enough holding, separated from her mother in an incubator for

months (Lunn & Pedersen, 2016). Gurevich (2014) suggested that the psyche continues to develop around the dissociated unbearable trauma and the fear of breakdown.

As I tried to write about this unhealed and unbearable trauma, I found myself feeling helpless, stuck and struggling to find words. My academic writing felt dry and experience-far, it did not capture the full meaning I had made from my reading. I started to see the description of 'falling forever' in books and TV. It called to mind the opening credits of the TV series Mad Men and more recently of The Flight Attendant. Both show a body falling endlessly through space. But it was the representation in Lunn and Pedersen's article, their client's description of her invisible terror that affected me deeply and eventually helped me begin to make an interpretive leap (Crowther & Thomson, 2020). Figure 3 is an image of falanga torture that evoked in me intense feelings of terror, horror and the visceral sensation of my stomach dropping and blood rushing in my feet and toes.

Figure 3

Bruising From Falanga Torture



Note. From "Dermatological findings after alleged torture", by L. Danielssen & O.V. Rasmussen, 2006, *Torture, 15*(2), p111, (https://irct.org/assets/uploads/1018-8185_2006-2_108-127.pdf). Reprinted with permission.

This image provided a visual representation of the terror of endlessly falling forever. Although I wanted to turn away from the helplessness and distress of the image above, I found myself able to remain integrated (Cohen, 2003; Turp, 2012). By creating space for these distressing feelings, I was able to connect to a deeper level of interpretation of the concept and those writers who have used the ideas in relation to the effects of premature birth on the psyche. At first, this image helped connect my academic thoughts to a felt somatic experience. But I then started to wonder about the

image as a representation of torture; the ongoing, haunting, debilitating pain. I became curious about the client's difficulty in making sense of her experience, to herself and with others. I kept this thought on torture percolating.

In the following, I will consider another conception of enduring feelings of helplessness and hopelessness relating to the effect of early trauma on the psyche.

Vulnerability to Overwhelm

As I talked to others about my interpretation of the experience as torture, I felt conflicted. Part of me wondered if it was too much, too intense, too distressing. But for whom? I immediately rebutted my wondering, as it has come to be my belief that it is exactly this too much-ness, this overwhelm that appears to be part of the premature baby's enduring experience.

Some writers drew on a Freudian concept of trauma to make sense of these enduring feeling states. Freud (1926) described trauma as an external or internal situation that is too simulating, causing a breach in or shattering of the protective shield. Urwin (1998) reflected that in early infancy, this protective shield may not yet exist, leaving the baby completely reliant on the mother to protect him or her from excessive stimulation. As premature babies are often separated from their mothers, the protective function for the baby may be seriously undermined and the painful procedures premature babies endure may be too stimulating and overwhelming, causing a trauma to occur. It was suggested that in some cases the frequent and cumulative traumas a premature baby experiences, coupled with the lack of access to a soothing mother, may prevent the protective shield from developing, leading to future vulnerability and a sense of hopelessness to establish in the personality (Emanuel, 1996; Urwin, 1998).

The trauma associated with premature birth and in particular the absence of the mother may affect the protective structure of the psyche, leaving it vulnerable to overwhelm and feelings of helplessness and hopelessness.

'Nameless Dread': Terror Stripped of Meaning

Several writers interpreted the presence of helplessness, hopelessness, terror and dread as unprocessed trauma, using Bion's concept of containment and in particular, his idea of a 'nameless dread'. Bion (1962) proposed that a baby is unable to process its raw sensory experience, which he called beta elements, on its own. The baby uses a mechanism called projective identification to communicate its experience to the mother and in the ideal process, which Bion called alpha function, the mother is able to think, give the experience meaning and respond appropriately (Bion, 1962). According to Bion (1962), if the mother is unavailable to receive this communication, the meaning of the experience is lost and is returned to the baby as a 'nameless dread'. In the context of a premature

birth, a baby may be faced with a daily struggle to survive, painful interventions, and a complete lack of adequate access to its mother. It is heart-breaking to imagine the distress they may try to communicate to no avail. I notice this stirs in me a sickening feeling to imagine the meaningless terror and dread that may infuse the psyche.

Reiner (2006) commented on her adult client's recurring feelings of overwhelming helplessness, hopelessness, terror and rage, that were connected to unreceived experiences as a premature baby, alone and invaded by chaos. It was interesting to note that rage was also connected to this experience in this instance, an emotion that reveals itself at times in the literature and remains curiously absent in others. Emanuel (1996) also connected his client's infant experience of separation from the mother to trauma that could not be processed, left without meaning in the psyche. Urwin (1998) and Blessing (2006) were more specific and interpreted their clients' 'nameless dread' as the failed communication of a fear of dying and struggle to survive as a premature baby. Mikardo (1995) reflected on the incubator as a containing refuge that was also contaminated with unbearably painful feelings. The idea of the incubator as both a refuge but also infused with pain made me wonder about the paralysing predicament of disorganised attachment, where the infant's source of safety is also frightening (Mikulincer & Shaver, 2016). Surprisingly, attachment styles were not often discussed in the literature, but Emanuel (1996) and Kupfermann (2005) both briefly referred to a tendency towards a disorganised attachment style in their child clients who had experienced trauma alone as an infant in their incubator. Emanuel (1996) reflected that raw beta elements that have not been processed through alpha function cannot be thought about consciously and may repeat as flashback dreams during Non-Rapid Eye Movement (NREM) stage of sleep. This reminded me of a paper I had read several years ago that connected night terrors with lack of containment in infancy (Anzieu-Premmereur, 2016) and made more sense of my own experience of night terrors that occurred regularly throughout my life until I began psychotherapy treatment.

As I reflected on the content of some of my night terrors, the representation of torture began to take more shape. Sometimes I would awake in panic, screaming, hallucinating a figure at the end of my bed, terrified in anticipation that I was about to be hurt. Other times, I would awake in terror and disgust that my pillow or face was crawling with ants or spiders. I started to imagine a prisoner, shackled and trapped in a small space. From time to time, someone appearing to deliver a brutal senseless torture. A body filled with terror and dread. To imagine that this could be the premature baby's experience is almost unbearable, my body is filled with grief.

I will turn now to the role of symbolic and verbal processes in infant development and their relationship with the long-term effects of trauma that emerged in the literature.

Getting the Message Across, But How?

As premature birth trauma occurs so early in life, there may be a tendency to experience emotional pain in the body, as memory traces of nonsymbolised and nonverbalised trauma (Blessing, 2006; Eekhoff, 2013; Mikardo, 1995). Alhanati (2004) described her client's nonsymbolised state of non-being to her experience of being alone in an incubator for three months. Kupfermann (2005) described the puzzlement of her child client's bizarre behaviour of walking on his toes and incoherent utterances of "bloody feet" and "needles in my feet", that upon presentation appeared psychotic. These symptoms came to be understood as a manifestation of the preverbal trauma of blood tests and intravenous feeding he experienced through his heels as a premature baby (Kupfermann, 2005). Another client's persistent head and mouth tic came to represent a dissociated yearning for his mother's breast as an infant (Willock, 2015). MacDonald (2015) commented on her child client's relentless physical movements and made sense of these as an attempt to ward off the terror of prematurely becoming aware of and being exposed to his own mortality. Eekhoff, (2013) described early infant trauma as "a disaster that cannot be communicated except unknowingly via the medium of the body" (p. 355) Eekhoff (2013) and Alhanati (2004) both emphasised using their bodies as therapists to understand and make contact with their clients' experience of nonsymbolic, nonverbal trauma. I thought about the burning sensations in my throat and chest that surfaced when I tried to make meaning of the literature. I recalled my inexplicably strong reaction of terror at the entrance of Madame Tussaud's Chamber of Horrors. I began to feel relief, comprehension and self-compassion as this previously not understood childhood experience made sense.

It was both startling and unsurprising to note that some clients were unaware of their premature birth history (Kupfermann, 2005), whilst others, in a similar way to me, were aware but had attached no meaning to the experience (Blessing, 2006). Given the impossibility of trying to talk about and make meaning of something which has no words or form, it ignited a strong yearning to find ways of clinically making meaning of a client's possible nonsymbolised, nonverbalised early trauma.

Finally, I will discuss the reliving and acting out of trauma that cannot be verbally expressed.

I'm the King of the Castle, and You're the Dirty Rascal…

Throughout this project, I felt moments of intense overwhelm. But it was during the writing that I noticed a desire to evoke overwhelm in the audience of this dissertation. It moved from an apologetic wondering if it was too much, to a bubbling excitement more representative of sadistic glee. I wanted to induce the same overwhelm, but now as a punishment. In the following, I share findings that relate to the acting out of trauma.

Some writers noticed sadomasochistic tendencies in their client's relationships and connected these to physical trauma suffered in the NICU environment. Kupfermann (2005) described these tendencies as an active re-enactment of the pain her client passively suffered in infancy and an attempt to master it by inflicting it on others. Turp (2012) considered her adult client's masochistic behaviours an unconscious communication of her primitive horrors. Emanuel (1996) and Mikardo (1995) noted a preoccupation with torture and violence in the drawings and play of their young clients and connected this to premature birth experiences which may have felt cruel, shocking and devoid of hope. Mikardo (1995) described her child client's grandiose taunting her in therapy sessions with "I'm the King of the castle and you're the dirty rascal" (p. 233). Willock (2015) described his young case study's chaotic and traumatising play as an "imitative identification with the aggressor" (p. 41) of the cold, lifeless, hostile NICU and incubator materials. Eekhoff (2013) described a client's identification with the aggressor as a defensive mimicry, reflecting the dependency and vulnerability felt during infant trauma when so many were felt as aggressors.

Many writers noticed an entanglement of pain and gain in their clients that appeared connected to the life-giving but invasive procedures their clients had experienced as premature babies (Alhanati, 2004; Blessing, 2006; Kupfermann, 2005; Mikardo, 1995; Reiner, 2006; Urwin, 1998; Wooldridge, 2018). Some writers noted that their healing-intentioned verbal interpretations during therapy appeared to feel painful and intrusive to their clients (Alhanati, 2004; Blessing, 2006; Kupfermann, 2005; Mikardo, 1995; Reiner, 2006; Urwin, 1998; Wooldridge, 2018). This was often coupled with the therapist struggling to reach and make contact with their client "my words felt like too much, too fast… like the mechanical probings of well-meaning doctors she had to endure at that time" (Reiner, 2006, p. 565). Alhanati (2004) reflected that her verbal communications were not in a form that could be used to understand the nonverbal and nonsymbolised unhealed infant trauma of her client.

Gurevich (2014) described nonsymbolic trauma compulsively repeating in enactments. Using a neuroscientific perspective, Holmes (2014) suggested that early trauma organises in the brain as implicit memory, causing primitive feelings to endure and compulsively repeat on instinct rather than be thought about. The premature termination of therapy was remarked upon by many therapists (Blessing, 2006; Kupfermann, 2008; MacDonald, 2015; Urwin, 1998). Eekhoff (2013) linked this with the idea of acting out nonsymbolised trauma of being repeatedly left in the incubator and longing for mother.

Early trauma appears to remain unhealed, as it has not passed through processes of symbolisation or verbalisation. Memory traces of early trauma may be shown in the body or through enactments like premature endings or attempted mastery of pain.

Chapter Summary

In this chapter, I have explored findings in the literature that connected premature birth experiences to unhealed trauma in the psyche. An enduring infusion of helplessness, hopelessness, dread and terror in the psyche revealed itself strongly in the texts and was often conceptualised as unhealed trauma. Moreover, it was suggested this trauma may create a vulnerability to future overwhelm and due to its form, may be doomed to re-enactment. The baby's experience of separation from the mother featured strongly as a significant factor contributing to trauma. Some of the enduring effects appeared to reflect the painful and intrusive medical interventions that were endured in infancy, whilst others reflected the fear of dying and struggle to stay alive. Overall, the literature suggested that physical and emotional traumas experienced during a premature birth appear to remain unhealed and have a lasting effect on the psyche. Through the process of dwelling in the material and creating space for my embodied responses, my interpretive lens of torture emerged.

In the next chapter, I will discuss findings relating to the development of the self.

Chapter Four: The Development of the Self

In the last chapter, I portrayed an image of a baby in an incubator for seemingly endless amounts of time, without reliable attuned maternal care and with painful intrusions, teetering on the cusp of life and death. I came to understand these experiences as torturous. In this chapter, I discuss findings that relate to the challenge of developing a self under these conditions. I will argue that a premature baby survives, continues to exist, but does not easily thrive. The early deprivation appears to distort the psyche with a series of adaptations. As I worked with the material to find meaning, I longed for clarity, cohesion and structure to emerge. Although this possibly felt like a part of any research process, I began to realise that my confusion and hindered capacity to coalesce the effects may also reflect the premature baby's experience of developing a self.

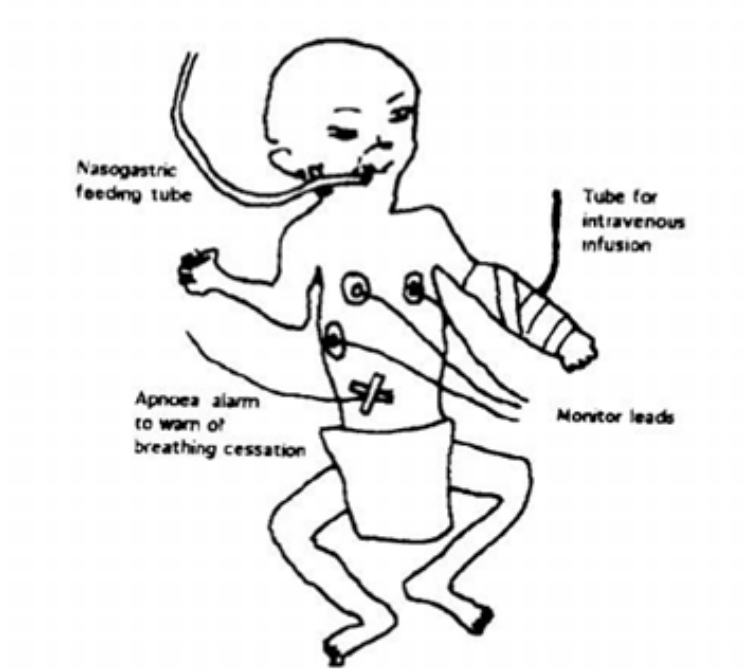
Holding Myself Together… To Stop Myself Falling Apart

According to Bick (1968), one of the baby's first tasks in its earliest days and weeks is to introject a containing object that holds parts of the self together when in states of unintegrated helplessness. This guards against a most primitive terror of falling apart or leaking away (Turp, 2012). This object may be sensory, like a sound or smell, but the ultimate containing object is described as "the nipple in the mouth, together with the holding and talking and familiar smelling mother" (Bick, 1968 p. 484). If a baby is unable to introject a containing function, the formation of a binding psychic skin is disturbed, creating a fragility in the developing personality (Bick, 1968). It is understandable that a premature baby who is exposed to so many moments of helplessness and an ongoing struggle to stay alive, with such limited contact with and care from its mother (her smell, her voice, her skin and her body) may struggle to develop this holding psychic skin. Could other containing objects be used in replacement?

As I wrote about this topic, I found myself desperate for reassurance, frantically searching for a containing object. I yearned for a person to sit next to me as I wrote, encouraging and supporting me when I felt stuck and helpless: the ultimate available, warm, soothing mother. In the end, I found comfort in the literature and, in particular, an article written by Lazar and Ermann (1998) who shared their painful and challenging experiences observing premature babies. They spoke of their unanticipated need for support and stability from their colleagues as they attempted to make some sense of such early life from their own fully developed minds (Lazar & Ermann, 1998). I felt less alone. I noticed my desire for soothing and making do with the available reality. I noticed that I kept coming back to the article, clinging onto it as something solid in the face of feeling lost and confused. I also recalled an image (Figure 4) I had seen in Margaret Cohen's (2003) tender book on her experience as a child psychotherapist in a NICU setting. I found this image particularly moving, returning to it many times through my reading.

Figure 4

Tubes and Monitor Leads



Note. From *Sent Before my Time: A Child Psychotherapist's View of Life on a Neonatal Intensive Care Unit* (p. 4) by M. Cohen, 2003, Taylor and Francis (Books) Limited. Copyright 2003 by Margaret Cohen. Reprinted with permission.

This picture captured the isolation, intrusion and helplessness of a premature baby's experience and helped me to more deeply understand the difficulties and adaptations that may develop in the self in response to feeling unintegrated and attempts to feel contained. I will now turn to ways the effects of these experiences on the developing self have been conceptualised in the literature.

Turp (2012) sadly alluded to her adult client's younger attempts at integration that included "rocking back or forth or banging her head against the headboard of her bed" (p. 78). Willock (2015) described a child client's play that focused on making fences to keep animals safe from the threat of violent attack. This was understood as representing his struggle to find comfort following his less than ideal early infant environment (Willock, 2015). In some cases, I noticed in the literature that inanimate objects could be used for comfort. Urwin (1998) noticed her client finding calm in his rhythmically bleeping computer game and related this to his experiences in the NICU environment, whilst Nilsson (2009) noticed the soothing effect of the rhythmic ticking of the clock. MacDonald (2015) set out an interesting idea of an 'incubator psyche', suggesting that the psychic skin of her client may have introjected the whole incubator, a non-human containing object, within his self-

boundary. This made sense of his uncanny ability to read the room physically and socially and intuit any changes (MacDonald, 2015).

Bick (1968) proposed that if the psychic skin fails to develop, a 'second-skin' formation can ensue, that looks like independence in adults but is a replacement for depending on others. Alongside this 'pseudo-independence', compensatory containing functions like verbal or physical muscularity often appear (Bick, 1968). This defense has been described as "a tough impermeable barrier around the self" (Turp, 2012, p. 68). Several writers commented on seeing in their clients a need for independence, and an aversion to needing another or seeking affection in relationships and linked this to their premature birth experiences (Blessing, 2006; Lunn & Pedersen, 2016; MacDonald, 2015; Wooldridge, 2018). To protect themselves from unbearable states of unintegration, a reliance on compensatory 'second-skin' functions like the elaborate use of language, love of knowledge to feel in control, and fixations with cycling (Lunn & Pedersen, 2016), athleticism (Blessing, 2006) or being in constant motion (Emanuel, 1996; MacDonald, 2015) were observed.

Bick (1968) considered disturbed psychic skin formation to be a result of disturbances in the infant feeding period. A further conceptual link between eating disorders[3] and premature birth experiences emerged in the texts. In anorexia nervosa, the experience of being thin was understood as a 'second-skin' holding the self together (Lunn & Pedersen, 2016; Wooldridge, 2018). The sensation of starvation appeared to generate a feeling of tightness in the body that felt comforting and could be relied on instead of depending on another (Blessing, 2006; Wooldridge, 2018). I was disturbed by, and at first resisted, a connection between premature birth and the later development of eating disorders (Alhanati, 2004; Blessing, 2006; Emanuel, 1996; Lunn & Pedersen, 2016; Turp, 2012; Wooldridge, 2018). But something shifted in my initial resistance as I found myself making a connection from the baby in Figure 4 and the repulsive and appallingly cruel act of force-feeding geese to produce foie gras, as seen below in Figure 5.

[3]The pathway to disordered eating, the psychic structures underlying symptoms and treatment approaches can differ markedly (Lunn & Pedersen, 2016), and a full consideration of their complexity is outside of the scope this project.

Figure 5

Duck Being Force Fed

Note. From Mulard Duck Being force fed Corn in Order to Fatten its Liver for Foie Gras Production by Olivierd, 2007, Wikimedia Commons (https://commons.wikimedia.org/wiki/File:Mulard_duck_being_force_fed_corn_in_order_to_fatten_its_liver_for_foie_gras_production.jpg). CC-BY-3.0.

The image in Figure 5 of a goose being force fed represented the boundary violation, horror and disgust of the premature baby's nasogastric feeding tube. Rather than feeling contained by the sensuous smell and feel of the external mother's breast, and the baby having control over its sucking rhythm and delivery of milk, the nutrients arrive through a tube directly into the stomach, causing distress. This image helped me to think more deeply, on a visceral level, about the experience; disturbances in feeding, difficulty in establishing a psychic skin, and a later connection with disordered eating.

I have reflected on ways the psyche of a premature baby adapts to limited contact with its mother. In the face of being unable to introject a containing object, the future capacity to depend in relationship is affected and compensatory ways of gaining comfort and integration develop. I will now turn to further adaptations in the development of the self and the impact on relating to others.

Holding On To You…To Stop Myself Leaking Away

Bick (1968) proposed that the failure to introject a containing object goes on to impede the development of an internal space within the self. This can give rise to a surface way of relating to

others, called ‘adhesive identification’ (Bick, 1986). This style of relating is conceived as an imitation of others rather than a reflection of internal values or sense of self (Meltzer, 1975). In this way of relating, physical or mental separation is considered painfully lacerating as it elicits the terror of leaking away or falling apart (Bick, 1986). In the context of a premature birth, a baby may not develop dependence on and gain lasting comfort from the mother as she is not reliably available. This can then affect the establishment or completion of an inner self and depth of future relationships. Turp (2012) described her client’s difficulty in establishing her own mind, often feeling empty on the inside, scrambled and confused. Lunn and Pedersen (2016) painted a picture of a co-operative, adaptable and agreeable self but with subordinate undertones that at times revealed her lack of a separate existence. Socially, the underdeveloped self appeared to be heavily influenced by the other’s point of view, with differences in opinions to be avoided at all costs (Turp, 2012). Fink (1989) used a different concept based on primary thought processes, but came to a similar understanding, noticing his client’s lack of inner space and superficial relating, and connected this to her premature birth. Although the growing premature baby fears vulnerability and dependency in relationships, it is also completely reliant on others for its survival. I started to form a picture in my mind of an impossible dilemma. Needing another for survival but being unable to take in lasting comfort. Feeling terrified of dependency but also any prospect of physical separation or differentiation. In the literature, an intense fear of separation and adverse client reactions to breaks in therapy were observed by many (Alhanati, 2004; Blessing, 2006; Bonovitz, 2015; Emanuel, 1996; Fink, 1989; Gurevich, 2014; Kupfermann, 2005; Reiner, 2006; Turp; 2012; Urwin, 1998; Willock, 2015; Wooldridge, 2018). Turp (2012) observed breaks in therapy appeared to engender life-threatening behaviours like not eating and suicidal ideation, and felt at times her client was “clinging on to me for dear life” (p. 70).

I will now turn to another conception in the literature that made sense of the lack of developed self and adaption to the other.

Disconnected and Over-connected

Some writers drew on a Ferenczian approach to early infant trauma that used different ideas but pointed to similar outcomes for the self. Ferenczi (1932) proposed that trauma in early infancy can cause aspects of the self to dissociate in shock. Gurevich (2014) suggested that premature birth experiences distort the psyche by dissociating the authentic self and creating an over-adaptation to the environment. The shock of the failed facilitating environment may inhibit the developing self’s sense of spontaneity, self-assertiveness and self-protection (Gurevich, 2014). Alhanati (2004) connected her client’s endless time in the incubator without enough comfort or holding, to a future inability to connect to an authentic voice in her writing career, a dissociative defense that coped with her infant terror. Over-adaptation can manifest and endure in relationships as a tendency towards suggestibility, lack of will or a motivation to serve the needs of others (Gurevich, 2014). Reminiscent of the

imitation described in ‘adhesive identification’, Eekhoff (2013) suggested that the loss of the authentic self affected her client’s personal agency, with a tendency for relationships to revolve around passivity and mimicry of the other. Mimicry made socialising in groups difficult as it was not possible to take on the form and shape of all of the others at once (Eekhoff, 2013).

Many therapists commented on finding it hard to reach and connect with clients who had a premature birth history (Alhanati, 2004; Blessing, 2006; Eekhoff, 2013; Fink, 1989; Lunn & Pedersen, 2016; Maiello, 2012; Mikardo, 1998; Nilsson, 2009; Reiner, 2006; Turp, 2012; Urwin, 1998). It feels reasonable to suggest that this difficulty may relate to connecting with an incomplete, scrambled or unavailable self. Eekhoff (2013) suggested that many therapies fail as the mimicry of the therapist remains undetected. Turp (2012) made sense of this difficulty with her client as a reflection of an expectation from infancy that she would not be seen and her needs would not be met, coupled with a burning hope to be found and her needs intuitively understood. Mikardo (1995) stated that her client was unsure if therapy would be beneficial or damaging, verbal interpretations highlighting a separateness between herself and her client that could not be tolerated.

I noticed that I felt impressed by, and compassionate towards, these tiny premature babies and their many creative adaptations. For the sake of survival, the self dissociates and the psyche distorts in resonance to the environment. I started thinking about a box of tangled wires, as illustrated below in Figure 6, how impossibly scrambled they appear, and how tiring and life-sapping it is to think about sorting them out.

Figure 6

Tangled Wires

Note. From iStock by Getty Images, by sytilin, 2014 (https://www.istockphoto.com/photo/interwoven-tangle-of-wires-on-a-white-background-gm521747689-50414688). Reprinted with permission.

I will next discuss findings in the literature that relate to a lack of aliveness.

Surviving, Not Thriving

As I thought about the premature baby's dilemma and its incredible, but scrambled, attempts to develop and adapt, it all felt impossible and too hard. I remembered a dream that had stayed with me. It was set in a village in medieval times. All of a sudden, the village was terrifyingly attacked and pillaged by a cruel mob. They were brutal. Somehow, I survived the raid. Alone and distraught, I curled up in the cold dirt, ready to die. This sense of survival but lack of aliveness in the psyche will be discussed next.

Ferenczi (1929) suggested that an infant needs to be called into existence and without this, may slip back into a state of non-being. Eekhoff (2013) related this idea to the premature birth experiences of suffering pain and separation from the mother and suggested that these experiences, in particular missing out on proximity to their mother's tenderness and care, affected the capacity to feel alive and created a psychic deadness. Blessing (2006) commented on her adult client's lack of liveliness, passivity and participation in life and noticed that often following an alive, engaged session, her client would miss the next appointment. Lunn and Pedersen (2016) witnessed their client's continuous inner struggle on the border of psychic life and death. Alhanati (2004) perceived a psychic entanglement of life and death, describing her adult client at different stages of therapy as lacking in vitality, despairing at the pointlessness in her existence and finally an urgent longing to stay alive. These findings reveal a self that may survive, but not thrive. I recalled a resounding plea from Catherine Vanier, a child psychotherapist in a NICU setting, for the premature baby to have their psychic life co-resuscitated alongside their medically aided physical existence (Vanier, 2015).

I will now return to a further enduring consequence of inadequate maternal presence and the initial problems with containment.

No Room to Think

Whilst Bick focused on her concept of the skin, Bion was working to extend his complementary idea of containment to a broader theory of thinking (Meltzer, 1986). Bion (1967) proposed that a space for thinking can develop only when the absence of the mother and separateness can be tolerated. In the context of a premature birth, the baby's ability to take in a containing object is hindered, which then affects the establishment of the inner self and the capacity to tolerate physical and mental separation. From this position, an internal space for thinking becomes thwarted. Many writers noticed in their clients a lack of ability to process and regulate their feelings (Alhanati, 2004; Bonovitz, 2015; Emanuel, 1996; Lunn & Pedersen, 2016; Reiner, 2006; Urwin, 1998), a lack of mentalisation (Lunn & Pedersen, 2016) and lack of self-reflective function in clients who had experienced a premature birth in their infancy (Bonovitz, 2015; Eekhoff, 2013; Emanuel, 1996;

Reiner, 2006; Urwin, 1998), and related these to a lack of early maternal containment. Blessing (2006) suggested it was hard for her adult client to make meaning, think about and learn from her premature birth experience as no meaning had been made by her parents. Eekhoff (2013) suggested that the process of mimicry reduced her client's separation anxiety but also destroyed her ability to think.

Reiner (2006) hypothesised a link between early infant trauma and a tendency towards synchronicity, the assignation of meaning to coincidental events, as a replacement for thinking. Although much longed for, her adult client's house move activated feelings of terror, confusion, helplessness and abandonment from her premature birth, which in turn affected her capacity to think (Reiner, 2006). The client began to feel confused between internal states and external events, and experienced a collapse in time; unbearable feelings and thoughts were projected and acted on, rather than being available for thought (Reiner, 2006). When her radio popped and broke, her client connected this with an argument she was having with her neighbours; their anger had caused the radio to die, alternative mentalisations rendered unavailable in this moment (Reiner, 2006). Synchronicity appeared to be most aroused in times of transition, crisis and major life changes, like birth, deaths and marriages and was understood as a way of coping with intense primitive mental states of terror, helplessness, hopelessness and dread of the unknown (Reiner, 2006).

These findings reveal a self with a limited capacity to think about themselves, others and their experiences. This ability appears to be particularly restricted in times of transitions in the face of intense primitive emotions.

Chapter Summary

The literature suggests that the medical intrusions, closeness to death and separation from the mother, inherent in the premature birth experience, have an enduring effect on the psyche. In particular, they appear to affect the development of a separate, animated self that is able to depend on others for comfort and to think about themselves and their experiences.

Chapter 5: Discussion

In this chapter, I summarise the findings in relation to my original question. I then describe my transformed understanding of the topic. Next, I consider the findings in relation to the current context and existing research. I then reflect on the strengths and limitations of the study, and suggest areas for future research. Finally, I discuss the implications of this research and make concluding remarks.

I began with the question: "What are the enduring effects of a premature birth experience on the psyche?". The overall findings from this literature review suggest a persistence of unhealed, nonsymbolised, nonverbalised trauma and a self that has creatively adapted to its early environment of deprivation. The literature revealed that the psyche appears to be haunted by feelings of overwhelming helplessness, hopelessness, terror and dread that make no sense and have no conscious meaning. The structure of the psyche can be affected and rendered vulnerable to future traumas. In the face of this difficult early life start, the developing self struggles to depend on others, instead finding alternative ways to gain comfort. Ongoing development of the inner self suffers from the need to over-adapt to the environment, which then impedes the adult capacity to reflect, think and make meaning. These creative adaptations distort the developing psyche and affect the capacity to feel truly alive.

Shifting Understandings

During my immersion in this project, there were key moments that profoundly shaped my understanding of the research and its context, providing moments of vision (Smythe & Spence, 2012). Throughout I struggled with the dominant socio-cultural narrative that babies do not have the capacity to remember. This struggle led to a gradual realisation of a hidden pre-understanding and to a lasting transformation of my understanding, an essential task of a hermeneutic journey (Schuster, 2013; Smythe, 2019).

Firstly, I will describe my discovery of the shifting nature of scientific truths. As I gained an understanding of the selected literature under review, I continued to read around the topic and became aware that the NICU setting is affected by an ongoing ethical controversy around an infant's ability to feel pain and the risks of pain management medicines (Cohen, 2003; Verny, 1999). I was shocked. Up until the 1980s, it was thought that infants lacked the neuroanatomical and neuroendocrine receptors that felt pain (Mancuso & Burns, 2009). In the 1990s, research began to emerge that neonates were in fact able to feel pain and that ineffective pain management had lethal effects on their outcomes (Mancuso & Burns, 2009). The debate then moved to concern over the best levels of analgesia (Mancuso & Burns, 2009). The debate still continues, as research now grapples with the complex nature of pain and the effect of anxiety and anticipation (Duff et al., 2020). In the absence of a baby's

capacity to verbally communicate, researchers have begun studying brain responses to try to infer a baby's subjective experience of pain (Slater, 2019). Encountering this debate prompted me to think about the temporality of the current socio-cultural context for the experiences of premature infants. If the scientific perspective on pain can change, perhaps it is possible the current dominant narrative that babies do not have the capacity to remember, can also change.

Grappling with the temporality of the pain debate coincided with New Zealand entering a strict lockdown in response to a COVID-19 outbreak. I thought about the parallels between COVID-19, difficulties in breathing, Intensive Care Unit (ICU) admissions and premature birth experiences. I freshly realised that the acronym NICU stood for Neonatal ICU, somehow this meaning had escaped me in its short form. It became obvious in casual conversations and in a brief online search that there is a cultural expectation that ICU admissions are considered to have a traumatising impact (Sahoo et al., 2020; Topçu et al., 2017). This comparison fuelled an increasingly frustrated line of questioning within me. Why wasn't the trauma of premature birth experiences acknowledged in our culture? I reconnected to the urgent, angry need to offer a voice for babies that was originally ignited by reading about Verny's frustration with society's blindness towards infant's traumatic pain (Verny, 1999). I recalled Blessing's suggestion that witnessing primitive anxieties can elicit detachment and turning away (Blessing, 2006) and the reflection from a NICU doctor who hoped the babies would not be able to remember what was done to them (Cohen, 2003). Was it too distressing to imagine how frightening and traumatising premature birth experiences can be?

Coincidentally, I saw an interview on television with a mother discussing her experience of giving birth prematurely. It was pivotal in illuminating the previously hidden personal pre-understanding that I was projecting (Maxwell et al., 2020; Schuster, 2013) into my research. Her baby had been born at 24 gestational weeks and by childhood had not developed any diagnosable adverse outcomes. She appeared to dismiss any long-term effects of his premature birth experience, implying that her baby's experience had left no visible traces on his psyche. My frustration turned into outrage. I started to become curious about my strong reaction and my ceaseless questioning of why it was that society believed a baby would not have the capacity to remember. I transcribed the interview into text form to help me explore the text and my interpretation (Schuster, 2013). I realised that fuelling my outrage was an answer from within me to those urgent questions: "because they don't care". I suddenly recognised that there had been an existing, previously unconscious, personal pre-understanding, that was influencing my relationship to the research. I had been approaching the study with an expectation that people do not care; that our society and culture does not care about a baby's experience; that our babies are suffering from neglect. As this belief became conscious, it became possible to think about. It made sense to me that I had previously imagined a large disinterested non-audience for this project.

With this new understanding in mind, I came across an article written by NICU nurses which further shifted my perception. One of the writers described her long-held concern over the psychological effects of the NICU environment, the lack of a professional framework to understand them and her relief at the adaptation of the Tavistock psychoanalytic infant observation model into their NICU nursing environment (Boyer & Sorenson, 1999). I realised then that society might care but has no way to think about a baby's experience right now. It also illuminated the disconnection between psychoanalysis and the medical world which was echoed almost twenty years later by MacDonald (2015), with a need to strengthen the bridges between the disciplines of psychoanalysis and the medical world. This article shifted my understanding of the socio-cultural setting, it lit hope in my soul and galvanised my anger into action. I began to feel hopeful and excited about the temporality of the current understanding of a baby's capacity to remember and further encouraged that it has a capacity to change.

Transformed Understandings

During the research process, my understandings were in dynamic dialogue with the research question (Maxwell et al., 2020). Although emotionally difficult, this led to a life-transforming experience. My position moved from a detached insider to an engaged insider with conviction and advocacy. My stance included the confident belief that premature birth experiences have an enduring effect on the psyche, leaving traces of unhealed trauma and an underdeveloped inner self.

Professionally, I was immersed in the research area, investigating unfamiliar theories, related disciplines and databases. My professional horizons widened to include the understanding that premature birth experiences can overwhelm and traumatise the infant, especially when they are separated from the mother and that the trauma tends to remain nonsymbolised, nonverbalised and unhealed. Furthermore, these traumatising experiences impact the development of the self, creating persistent adaptations in the psyche. Personally, I experienced feelings of excitement, resistance, anger, confusion, panic and helplessness, with an ongoing desperate need for structure and containment. I found ways to create space for my feelings that allowed integration and critical reflection to develop. My personal horizons widened to include a broad range of previously unfelt feelings, a connection with my neonate self and meaning-making of the experience as akin to torture emerged. I experienced anger, distress and confusion as my previously hidden belief that society does not care about the experiences of premature babies surfaced. In dialogue with myself and the data and in an effort to expand my horizon further (Smythe, 2019), I went back to the literature, and re-read articles that noted entanglements between pain and gain. I considered afresh how it made sense for a premature infant alone and suffering chaos and pain, to decide on a nonsymbolic and nonverbal level that nobody cares. Perhaps my previously hidden belief may have developed from my own experiences as a premature infant.

My understanding of the socio-cultural context broadened as I interacted more deeply with the topic. I began with unease about the dominant socio-cultural narrative that babies do not have the capacity to remember. I encountered the changing perceptions of an infant's ability to feel pain. I then became aware of my existing belief that society dismisses the baby's experience because they do not care. This was a critical development as it had been in danger of deafening me in my dialogue with the literature (Gadamer, 2013; Maxwell et al., 2020). As my horizons widened, and I worked through parts of the hermeneutic circle, further reading challenged my belief that society does not care and instead suggested that society's current dismissal may come from a lack of framework to think about the baby's experience and its impacts, along with a disconnection between the medical and psychoanalytic worlds.

Findings in Context

My research findings challenge the current context. In Chapter One, I described the medical interventions that premature babies endure in an effort to stay alive. They suffer painful and intrusive procedures, and are often separated from the mother in special hospital units and incubators. I noted how unbearable it can feel for others to bear witness to this, often evoking emotional detachment or a turning away in parents and medical staff. My understanding of the current context grew as I faced the dominant socio-cultural belief that babies do not have the capacity to remember. My findings challenge this belief. They suggest that adults do in some form remember these experiences as the psyche appears to be enduringly affected by unhealed trauma. In particular, my findings suggest that the experience of being separated from the mother radically heightens distress. The lack of maternal protection in the face of pain and near death appears to significantly contribute to enduring trauma in the psyche. I believe that the narrative that babies cannot remember echoes the baby's initial failure in containment and meaning-making. The effects continue to remain unrecognised, trauma continues to remain unhealed in the psyche.

Through shifts in my understanding of the topic, I believe that with more research and a framework for understanding, there is hope that this narrative is open to change. Current neuroscience suggests that although adults struggle to remember autobiographical memories from before the age of two, the procedural memory is already in action (LoBue, 2022). The inability to remember may be due to the difficulty of retrieving memory that has no verbal narrative (LoBue, 2022). My findings support this idea as many therapists observed the presence of nonsymbolised, nonverbalised trauma in the bodies of their clients, and in the unconscious, repetitive acting out of their experiences in relationships. My personal interpretation of the literature revealed a hidden aspect of the experience that I understood as torturous. Perhaps this interpretation, along with my findings could begin to provide an accessible framework for others to think about the baby's subjective experience and the possible enduring impacts on the psyche. I am hopeful that if the narrative that babies cannot

remember can change, some meaning can be made of the premature baby's experience, which can then allow the trauma to be healed.

The research findings also support and extend the current context. Currently, there is a growing appreciation for the baby's attachment experience, including the promotion of skin-to-skin contact and psychological support for the medical teams and parents. This research supports the value and significance of the physical and emotional availability of the mother. It extends current knowledge by demonstrating possible ongoing traces of the effects of separation that are unlikely to be diagnosed but nonetheless impact the adult psyche. The findings attempt to strengthen the bridges between psychoanalysis and the medical world by taking a psychoanalytic perspective on a highly medialised experience.

The interaction of my findings, understandings and the current context, created many more questions for future exploration. Is society's dismissal of the baby's capacity to remember because they do not care? Is it possible to change the dominant perception that babies do not remember? How do I give voice to the baby? Why does our mainstream culture not know about these ongoing effects to the psyche that have been observed by psychotherapists? Might it be possible to start a new narrative that early infant trauma, held in the implicit memory, cannot be verbalised but still has the potential to impact the psyche? Is it possible to find a way to support meaning-making for the developing baby, their families and those working in the medical system?

Findings and Existing Research

In Chapter One, I noted that existing quantitative research highlighted associations between premature birth and adverse physical and mental health outcomes. The findings in the study support existing research on emotional, social and cognitive function. They indicate difficulties with overwhelm and distress, in forming close relationships and developing the capacity to think and learn. This study offers support to existing research linking premature birth with disordered eating. My findings suggest that disturbances in the formation of the psychic skin of the premature baby and the lack of ability to introject a containing function may be contributors to later eating difficulties. Further, my personal interpretation of the literature on eating disorders considered a comparison between the violation, horror and disgust of the nasogastric feeding tube and the cruelty of force-feeding. This offers a subjective and rich interpretation of the human experience. My findings did not directly offer support for the presence of sleep disturbances, however, I made a tentative link between the prevalence of raw beta elements that may be communicated by a premature baby and remain unprocessed as night terrors. This study suggests a future vulnerability to overwhelm from a shattering of the psyche's protective shield, which gives support to studies that have observed the existence of heightened stress responses and cortisol levels in those who have experienced their own premature birth. I believe that this study supplies a richer, more complex, account of effects that have

been found in existing quantitative studies and may also provide an understanding on effects that may not satisfy diagnostic criteria.

This study augments the existing qualitative research on the premature birth experience for parents by interpreting a possible subjective experience of the baby, which is currently missing. It is my personal meaning of the experience that came from the literature of an endless torture, on the verge of life and death, and all alone. It gives voice to the baby, provides a possible way of thinking about the baby's experience and contributes to the emerging qualitative evidence base of knowledge on the topic. Previously, Wilkinson (2005) investigated attachment styles of developing premature babies and found there were many factors influencing the security of the mother-infant dyad. Although, attachment did not emerge strongly from this review, my findings point to a possible tendency towards disorganised attachment, developing from the predicament of time alone in the contaminated refuge of the incubator. Previously, MacDonald (2015) suggested that premature babies may include the incubator within their psychic skin, rendering them hyper-aware of their surroundings. This study noticed other cases of inanimate objects being introjected for comfort and containment, offering support to this idea. This study also found that premature babies may have a tendency to over-adapt to the environment, in reaction to the shock of a failed facilitating environment, which also supports this idea, using a different theoretical concept.

Strengths, Limitations and Future Research

I will now consider the strengths of the research. This study offers a synthesis of existing psychoanalytic thought on the topic of premature birth. Through attuning to the texts, creating space for my embodied responses and crafting stories, my interpretive lens of torture emerged. I believe this interpretation provides a possible experience-near understanding of the premature baby's context, which contributes a new, salient perspective on the topic and gives voice to the baby. It provides new thinking on a phenomenon which is hard to think about it, as it is distressing, and hard to study, as it is challenging to access the subjective experience. By paying attention to the temporal and cultural context (McCaffrey et al., 2022), this study revealed that these effects are not currently widely recognised in our socio-cultural setting, and illuminated a possible opportunity for this to change. The methodological attentiveness to context (McCaffrey et al., 2022) allowed me to grapple with the current dominant narrative, that babies do not have the capacity to remember. At the moment, mainstream society fails to recognise and make meaning of premature birth experiences. But through thought-sharing, describing a framework for understanding and strengthening bridges between the psychoanalytic and medical disciplines, this has the exciting potential to transform. This contribution satisfies Yardley's quality criteria of impact and importance (Yardley, 2008).

Positivist researchers may question the value of interpretive qualitative research on epistemological grounds, however, given the strength of my feelings through the research, my

struggle to engage and to remain integrated, I am grateful for a methodology that encouraged my subjectivity, reflectivity, interaction and meaning-making. It also allowed a hidden pre-understanding to emerge which has had a personally transformational effect.

My findings and specific interpretation of the experience as torturous were highly influenced by my horizons and a different researcher may have arrived at a different understanding. This study could be considered limited in its lack of ability for replication or generalisation, however this is not the aim of a hermeneutic project (Crowther et al., 2017); this study demonstrates congruence with hermeneutic philosophies and in its application to the method (McCaffrey et al., 2022). Another limitation of this study is in the socio-cultural perspective of the researcher and the selected psychoanalytic literature. As a Pākehā woman researching articles written in the UK or the USA, the relevance of my findings to indigenous and non-Western cultures and communities with differing birth practices and concepts of self-development is uncertain and calls for further exploration. Within the 19 selected journal articles, there was a mix of client ages and gender, however there were more adult females and more child males in the body of literature. Perhaps there are effects yet to be revealed amongst female children and adult males. In this research, I did not make a distinction between sub-categories of prematurity. Babies who are born very early are more likely to receive more interventions, be separated from their mother for longer periods and suffer further on the cusp of viability. This research does not provide evidence in relation to these differences and suggests an important area for future research. The articles were published over a 30 year period. During this time, medical breakthroughs allowed babies at younger gestational ages to survive, and practices around pain management and infant-mother skin-to-skin contact evolved. An understanding of historical progression in medical practice in relation to the topic was not within the scope of this project, which again points to an area for future research.

This topic would benefit from qualitative research that gains insight on the adult's subjective lived experience of premature birth. In Chapter Two, I briefly referenced the challenges inherent in collecting data regarding nonverbal, nonsymbolised experience. One way to overcome this in a future research project might be to use a method that of data collection that accesses embodied implicit memories as others have done using an Interpretive Phenomenological Analysis with pre-reflective, pre-verbal material (Boden & Eatough, 2014; Boden at al., 2018).

Implications of this Research

This study has been personally meaningful. It has transformed my understanding of my own premature birth experience, significantly contributed to my development as a psychotherapist and shifted me into a position of advocacy for premature babies. This study may be useful to trainee psychotherapists as an addition to the curriculum as it contributes to and enriches the understanding of psychoanalytic theory and infant development.

This study may be useful to psychotherapy practitioners and other professionals working with children, adults and families who have been through the experience of a premature birth. It may help psychotherapists make meaning of body responses, relational enactments, and entanglements between pain and gain that might be observed in their adult clients. It may provide more understanding on a therapist's difficulty in connecting with their client, feeling separate but not relied upon.

The study may be helpful to nurses, doctors and medical staff working in NICU environments, as a different way of understanding the inner world of their infant patients. It may help to fortify the important bridges sorely needed between psychotherapy and the medical world.

In tandem with advancing medical treatments and the growing number of people who experience and survive a premature birth every year, it is increasingly important to consider the impact of these life-saving interventions on the infant and as the infant develops into adulthood. I have a fervent wish that our current socio-cultural narrative that babies do not remember can evolve. Perhaps this study can contribute in some way to the progression of thought and recognition of our babies' experiences.

Concluding Remarks

In this study, I have gained a deeper understanding of the enduring effects of a premature birth on the psyche. I have suggested that the development of the self is impacted and the psyche is haunted by unhealed trauma, and have come to see this experience as akin to torture.

Originally motivated by my own infant experience and a lack of qualitative research on the area, I have come to understand these effects in a visceral, life-changing way. My understanding of the broader socio-cultural setting has progressively shifted from disinterest to the need for a framework for thinking about the experience.

I am hopeful that this traumatising early life experience and its long term implications can be better understood; that trauma can be healed and the self can flourish.

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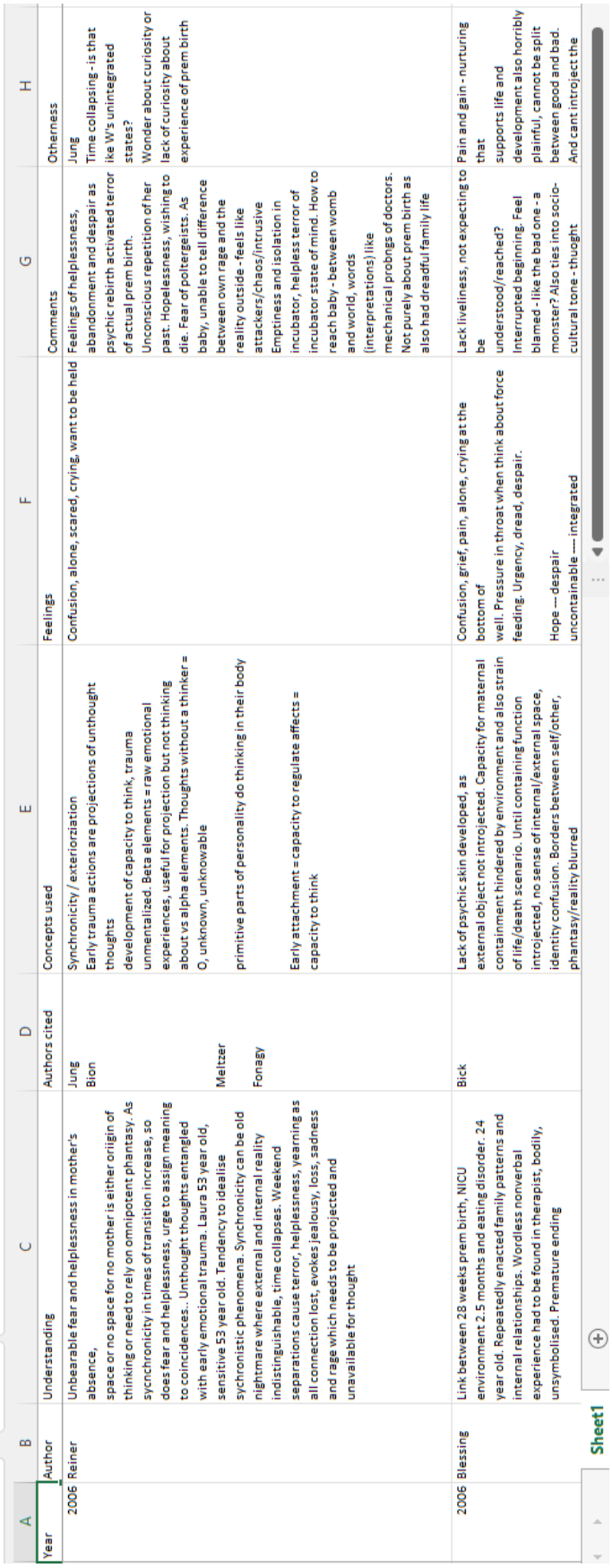
Appendix A: Excel Mapping and Classifying System



Year	Author	Understanding	Authors cited	Concepts used	Feelings	Comments	Otherness
2006	Reiner	Unbearable fear and helplessness in mother's absence, space or no space for no mother is either origin of thinking or need to rely on omnipotent phantasy. As synchronicity in times of transition increase, so does fear and helplessness, urge to assign meaning to coincidences.. Unthought thoughts entangled with early emotional trauma. Laura 53 year old, sensitive 53 year old. Tendency to idealise sychronistic phenomena. Synchronicity can be old nightmare where external and internal reality indistinguishable, time collapses. Weekend separations cause terror, helplessness, yearning as all connection lost, evokes jealousy, loss, sadness and rage which needs to be projected and unavailable for thought	Jung Bion Meltzer Fonagy	Synchronicity / exteriorziation Early trauma actions are projections of unthought thoughts development of capacity to think, trauma unmentalized. Beta elements = raw emotional experiences, useful for projection but not thinking about vs alpha elements. Thoughts without a thinker = O, unknown, unknowable primitive parts of personality do thinking in their body Early attachment = capacity to regulate affects = capacity to think	Confusion, alone, scared, crying, want to be held	Feelings of helplessness, abandonment and despair as psychic rebirth activated terror of actual prem birth. Unconscious repetition of her past. Hopelessness, wishing to die. Fear of poltergeists. As baby, unable to tell difference between own rage and the reality outside - feels like attackers/chaos/intrusive Emptiness and isolation in incubator, helpless terror of incubator state of mind. How to reach baby - between womb and world, words (interpretations) like mechanical probngs of doctors. Not purely about prem birth as also had dreadful family life	Jung Time collapsing - is that like W's unintegrated states? Wonder about curiosity or lack of curiosity about experience of prem birth
2006	Blessing	Link between 28 weeks prem birth, NICU environment 2.5 months and eating disorder. 24 year old. Repeatedly enacted family patterns and internal relationships. Wordless nonverbal experience had to be found in therapist, bodily, unsymbolised. Premature ending	Bick	Lack of psychic skin developed, as external object not introjected. Capacity for maternal containment hindered by environment and also strain of life/death scenario. Until containing function introjected, no sense of internal/external space, identity confusion. Borders between self/other, phantasy/reality blurred	Confusion, grief, pain, alone, crying at the bottom of well. Pressure in throat when think about force feeding. Urgency, dread, despair. Hope — despair uncontainable — integrated	Lack liveliness, not expecting to be understood/reached? Interrupted beginning. Feel blamed - like the bad one - a monster? Also ties into socio-cultural tone - thuoght	Pain and gain - nurturing that supports life and development also horribly painful, cannot be split between good and bad. And cant introject the