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Case Report
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Mother-Infant Relationship in NICU and Feeding Difficulties: A Case Study Approach

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Abstract
Numerous studies have already revealed that prematurity is an extremely traumatic event both for the mother and the infant. The mother is traumatized bodily and psychologically. It seems as a narcissistic wound but also as a repetitive trans-generational scenario with risk for the appearance of post-traumatic stress and postnatal depression. For the new-born, the separation of the mother-infant dyad due to hospitalization has a detrimental role for its psychical evolution. Deprived from the early interactions, visual and sensory, provoke a dysfunction in the process of attachment. Prematurity is also responsible for neonatal morbidity and other pediatric consequences: neurological or feeding difficulties, psycho-motor, visual, respiratory and cognitive. During hospitalization contradictory emotions emerge, towards the professionals in the NICU. More specifically, this case study is extremely representative since it describes the mother-infant separation, the in adaptive corporal exchange as well as Oro-alimentary difficulties, and their symbolization in the family context. Under this framework, we will discuss the following aspects: (a) the observation of the clinical manifestation; (b) the relational dimension and function of the symptom; and (c) the therapeutic intervention during clinical sessions.

Keywords: prematurity; narcissistic trauma; post-traumatic stress; attachment

Introduction

The scope of this work is to briefly present the risks and challenges of premature birth. A number of technical report series held by WHO between 1948 - 1950 recognized the term prematurity for international usage. A considerable number of infants that are born prematurely each year survive due to recent progress in perinatal medicine. Prematurity is defined as a birth occurring prior to the 37th week of amenorrhea (Penell, 2012) and concerns about 5%-18% of births and great prematurity about 1,5% of births globally. Prematurity is the leading cause of neonatal mortality. The lower the gestational age and the birth weight of the infant, the higher the consequences of prematurity (Mazet, 2003). Premature infants present several vulnerabilities concerning their respiratory function, cardiopulmonary rhythm, central nervous system as well as intestinal, immunological, hepatic and renal immaturity (Laugier, 2006; Kloeckner, 2006; Hadchouel, 2013). Prematurity is a multidimensional phenomenon, difficult to evaluate, and has short- and long-term impact on public health. Accordingly, it is estimated that the cost of premature birth is 30 times higher than that of a term birth (Missonier, 2012). For this reason, early prevention mesures are of great importance (Mazet, 2003), In the family context (Eliacheff & Szejer, 2003) prematurity can cause marital and family problems, which have impact on siblings, especially when prematurity generates a handicap.
Certain researchers describe a link between stressful events and prematurity (Lobel, 1992; Klauss, 2013). Yet, indicate **"Risk of Preterm Birth"** during pregnancy as an increasing risk factor intensifying the preexisting generalized anxiety. Mothers giving birth prematurely often have similar personalities. We observe the same signs of stress, anxiety, dependence and immaturity. In some cases, the feminine identity seems fragile while incidents of somatization elaborate of the existing ambivalence and could take different forms (Missonier, 2012; Misund, 2012, 2016; Apter,

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2013). We may observe contradictory feelings mainly due to body transformation while the arrival of the newborn could be perceived as threatening. (Missonier, 2012).

Both mother and child experience the rupture from the early separation. Hospitalization and separation traumatize maternal identity and alternate her concern. which are lost in the ambivalence of investment and disinvestment states (Soule, 1982; Lebovici, 1994; Forcada-Guex, 2011). Maternal representation and attachment initiate along with the first fetal movements. In fact, the gestational period of 24-32 weeks is a crucial period for the development of maternal representation (Klauss & Fanaroff, 2013) This separation does not facilitate the necessary mourning process for the loss of the imaginary infant developed during pregnancy and the failure she experiences after not being able to terminate the pregnancy and deliver a healthy child (Druon, 2005). As for the father, he is divided between the stressful hospitalization of his child and his wife (Houzel, 1999; Gamba, 2009; Morisod-Harari, 2012; Koliouli, 2014). Parents have overwhelming feelings of failure, guilt and shame, feeling deprived of their parental role. The hospitalization of their infant obstructs closeness and intimacy (Meyer, 1993, 1995) and parents receive information for their newborn mostly from the medical and nursing team. Hence, they are not any more privileged to be the only ones to talk about their newborn to others (Flacking, 2012; Fleck, 2016).

Premature birth is not only an emergency situation but a non-normative transition to parenthood that leads to an emotional crisis characterized by intense psychic vulnerability that may take the form of perinatal post-traumatic stress disorder or even postnatal depression (Meier, 1996; Pierre Humbert, 2003, 2004; Kersting, 2004; Olde, 2005; Korja, 2011; Apter, 2013). The trauma of premature birth is external, but in most cases, it emerges pre-existing vulnerability (Dayan, 2002; Olde, 2005; Missonier, 2012; Morisod-Harari, 2012; Apter, 2013). The mothers of premature infants manifest a range of expressions: anguish of death, widespread anguish, feelings of frustration and hostility (Venditelli, 2002). Another percpective proposes that premature mothers undergo **narcissistic injury** associated with great psychological difficulty, social exclusion, devaluation by her spouse (Soule, 1982; Lebovici, 1994; Meyer, 1995; Holditch-Dans, 2003; Muller-Nix, 2009; Klauss, 2013; Koliouli, 2014). Apart from the premature infant's biological vulnerabilities the prolonged hospitalization, although lifesaving, destabilizes the developmental needs of the infant. The limited physical availability of the baby and the absence of interaction, created by lifesaving equipment (incubators, monitors, feeding tubes iv lines etc.) seems very annoying.

For Brazelton, all infants are programmed to interact with their surroundings, (Brazelton, 1975), while the premature child is in restrain facing multiple limitations. Several studies point out that early maternal deprivation can be disastrous (Aubry, 2003; Muller-Nix, 2009; Flacking, 2012; Vanier, 2013). For the little man to become a subject, it will be necessary for Another to assume that the child is a subject. This is the way to give the child a sense of existence (Vanier, 2013). The maternal feeding strengthens repetitively the connection of the mother infant dyad and for some researchers this routine is a repetitive renewal and support of the relationship. (Mazet, 1993). Similarly, mother's lack of response to infant crying does not permit the establishment of early interactions (Mazet, 1990, 2003; Kreisler, 1995), thus, according to Winnicott, enables the construction of a "**continuity of being**". Premature newborns are exposed to an artificial and hypo stimulating environment (Kreisler, 1995; Druon, 1996) where holding, skin contact and olfactory experiences related to feeding moments are rare. The mouth which is normally the junction of experiencing the feeding, breathing and pleasure function, will be the pathway to the implementation of treatment (intubation, enteral nutrition). The orofacial areas become a source of distress. While being hospitalized in NICU most infants undergo consecutive unpleasant stimulation, prolonged feeling of frustration, bodily contact with their mother is quite limited due to their fragility and respiratory incapacity. Given this, several great researchers structure their observations interpreting newborns' clinical and somatic expression as an echo of the maternal behavior. (Klauss, 2013; Druon, 1996; Mazet, 2003).

As a result, the experience of active feeding moves away, not supporting the attachment process. Prolonged hospitalization risks attachment difficulties for the newborn who cannot express himself while constantly influenced by unpleasant medical interventions. These medical interventions can cause babies to try to push or turn away from any object approaches their facial area even a pacifier, feeding

bottle or mother's breast. This worrisome condition identified as **oral aversion** includes also signs of significant distress during feeding causing them to receive inadequate nutrition. Infant **oral aversion** frustrates parents, caregivers and babies themselves, resulting in psychosocial and medical complications such as poor growth, impaired parent-infant bonding, lack of parental competence and infant-parental distress.

This paper is based on the theoretical context proposing that:

a. The initial imaginary representation of the infant, develops during pregnancy,
b. It is comprised of both conscious and unconscious contributions that are influenced by the mother's personal history and
c. By her present life with her significant other.

For this reason, this exploration incorporates infant's observation from 0 to 5 months, the evaluation of the maternal historical background, analysis of semi structured interviews, narrated material of clinical sessions during the hospitalization in the NICU and the anxiety rating auto questionnaire (PPSDQ).

More specifically we will focus on:

a. the interruption of a woman's internal representation development of the child and of herself as mother,
b. the vulnerabilities of infant's developmental process,
c. the appearance and handling of infant's **oral aversion** as an outcome of prematurity and early maternal deprivation.

The observation's setting is the NICU Department of a Public Hospital in Greece. Our study is in line with the ethical recommendations of the Helsinki Declaration and did not receive financial support.

Clinical case

Historical background

The baby girl, whom we shall call Mary, is the first child of a couple, born at 27-week GA, in July. Her mother whom we shall call Anna, age 42, after being married for about a year, visited a FMA center. Although suffering from type A diabetes and despite the medical proposals which underlined a high-risk pregnancy, she decided to pursue her desire. Eventually, she gains a pregnancy and hopes for a personal triumph and an ideal child. The story of this family is inter alia very interesting. Anna is very attached to her mother as well as to her father, who died after long hospitalization, a few months after Anna's wedding. Her brother had died at the age of 18 when Anna was just 12. It was an incident of aspiration during his sleep. Anna, during her visits to her hospitalized father utilized a small apartment, which was the place where her brother passed away. It was a place of symbolic sacrifice, a place of suffering and negotiation linked both to the loss of her sibling and the loss of her father. The observation begun with the theme of hospitalization and loss. All her pregnancy will be linked to a series of somatic incidents that recall the incident of the loss of her brother. Apparently, the incidents of vomiting during pregnancy, apart from medical evaluation, hold a symbolic meaning and may be perceived as a somatic expression of intense emotional distress (Missonier, 2012; Misund, 2012, 2016; Apter, 2013). During the sessions she used to say: "one week following the FMA, I felt the first signs of pregnancy, and I suffered from severe vomiting". Hyperemesis graniolarum is a serious condition in which the repetitive nature of vomiting could be responsible for hydro electrolytic disorder and nutritional deficiencies (Delcroix, 2014). The upcoming event of birth gradually became a potential threat. Medical complications caused by the non-observant diabetes and hypertension brought her to a state of preeclampsia (PE). This extremely dangerous situation for both maternal and fetal health necessitates transfer to an equipped perinatal center and immediate caesarean section.

Observation

Day 1

The tiny baby girl weighs only 790gr. and has to be resuscitated several times. During resuscitation efforts, after a cardiac arrest, thoracic compressions (TC) result in a diaphragmatic deformity. The frequency of these incidents is greater in preterm infants with very low birth weight. In addition, she is diagnosed with broncho-pulmonary dysplasia and invasive respiratory support is required. The infant is immediately put on endotracheal assisted ventilation. Her nutritional needs are dependent upon parenteral nutrition (PN).

Day 7

A serious neonatal infection deteriorates rapidly the infants' situation and prolongs the intubation. Later Anna reports having feelings of extreme guilt since she associates the ongoing of medical complications with her departure. She also demonstrates partial loss

of memory. “I struggled, the moment I was forced to leave my little daughter in the NICU and return home” states Anna.

Day 12

Ultrasound reveals findings of stage III intraventricular hemorrhage (HIV). It should be noted here that Periventricular and Intraventricular Hemorrhages are the most common forms of Intracranial Hemorrhage during the neonatal period. The incidence rate varies inversely with gestational age, its frequency has decreased significantly in the recent years and occurs on average in 10% to 20% of infants with a gestational age of less than 32 weeks (Guzzeta, 1986; Laugier, 2006).

Month 2 (August)

Day 19

Mary recovers from the neonatal infection but remains on endotracheal intubation. Minimal enteral feeding is initiated.

Day 22

Transition from endotracheal intubation to CPAP, Although the respiratory support of continuous positive airway pressure (CPAP) is quite relieving for the infant in comparison to the intensive endotracheal intubation, still sets the boundaries and special limits between the parents. This situation is a source of stress with respect of the infant-parent relationship. Separation, non-feeding, not having free time to spend with the traumatized infant and a sense of being unable to help or caress make them distant or free zed and sometimes hostile to the caregiver.

Comments August

During the infant’s hospitalization in the NICU the mother exhibits a defense pattern conceptualizing the baby’s existence and ownership. This is a typical illustration of maternal disinvestment for the premature newborn. She keeps saying “this newborn is not ours but she belongs to God”. Anna also states during the interviews that she has already faced a similar tragic family incident. In fact, she underwent the stress full procedures of receiving the body of her brother’s premature newborn who did not survive. It seems possible that Anna cannot validate her existence as mother but continued to be her mother's favorite child (Druon, 2005). Studies indicate that maternal perception regarding leaving the state of pregnancy equals the loss of protection from significant others. For this reason, she feels more comfortable being with her mother than being next to her infant. The sense of belonging to her mother is clearly defined in her internal representation since some attachment studies propose that limited infant contribution alternates maternal behavior. Though, on the other hand her own maternal representation as a mother is almost nonexistent. Given this, Anna continues visiting the NICU rarely, limiting the maternal physical availability to the infant. Premature delivery interrupts a woman’s internal representation development of the child and of herself as a mother. Therefore, a demanding psychic work is needed to alleviate the existent internal representation so as a woman could acquire a maternal identity. Nevertheless, studies on mother-infant interaction indicate conflicting results, often difficult to achieve. In particular, Anna has a great difficulty to create an image of herself as a caregiver. For this reason, it seems easier for mothers of premature infants to receive active care giving from the NICU than becoming the caregiver themselves. It seems that the nursing stuff and the NICU itself becomes the maternal substitute for the mother and infant simultaneously (Mazet, 2003).

Day 28

The nutritional model gradually includes a combination of parenteral and enteral intakes.

Day 42

Corrected age 32 weeks

The target intakes to support her development were achieved by a combined model of enteral and parenteral nutrition. The parents live far away from the hospital. Not only do they have to cover a real distance but also and especially a psychic distance. During the mother infant observation, we observe indicatively, less vocalization, reduced facial expression and rare mother smiling. From the onset of the therapeutic sessions the mother is identified as having significant emotional difficulties. In parallel, a conflictual ambiguity of identity is established in the mother who has to adapt not only to her new role, but also to the existence – non-existence of her child.

Month 3 (September)

Mary remains on assisted ventilation CPAP. The existing combined nutritional model is characterized as efficient.

Observation October

Mary’s health condition is stabilized and she begins to breath without assisted ventilation. During this period, the parents visit the infant two or three

afternoons per week. Undoubtedly, the mother demonstrates insignificant involvement as far as it concerns maternal sensitivity interaction and behavioral communication skills while trying to reach her **"primary maternal preoccupation"**. Undoubtedly, Anna has increased perinatal risk factors resulting in sleeping and eating difficulties.

End of October

The medical team decides to initiate her to a preparatory faze of feeding by bottle. Premature infants present inability to extract fluid from the bottle or breast safely. As well as transport these liquids from the back of the throat to the esophagus. They lack neurodevelopment maturation and need further appropriate support and assistance to acquire this ability.

Observation November 1st

First attempt to bottle feeding

At corrected age of 1 month Mary is particularly agitated in the view of the nursing bottle and shows a particularly intense refusal. We identify an intense symptomatology of oral aversion. This is a post-traumatic reaction. The mouth, which is normally a zone of pleasure, has gradually become, after the care, an area of displeasure, a source of anxiety and this is expressed by her refusal to eat. An additional hypothesis attributing eating difficulty to the absence of her mother. Though she was experiencing the sense of hunger and the feeding bottle was offered to her, she remained upset, crying and with persistent muscle rigidity, without succeeding to gain gratification from the milk intake. In a psychoanalytic point of view the first recognition of reality on the part of the infant is in deciding whether to swallow an object or spit it out, hence the spitting out of the milk intake by Mary could easily give as the impression of a state of frenetic orality. The feeding bottle has been turned to a behavioral sign of distress and agitation. Apparently, Mary recalls her prior knowledge and negative experience and subscribes the appearance of the bottle as an invasive instrument similar to the medical procedures she has already undergone.

Observation November 15th

We decided that it is essential to intensify the efforts to support the interaction between the mother and infant. The distance represents an additional obstacle so we propose a temporary stay in the capital to ensure a more flexible visiting schedule. The goal of this intervention is to place a firmer context of coherent reciprocity. The infant has been already identified as having difficult patterns of temperament and behaviorally inhibited. All of these characteristics are attributed mainly to the mother's ability to parenting her child. The mother has to be present in order to physically be introduced to her child through feeding, overcome her corporal symptom and psychic tension and reduce her feeling of maternal incompetence.

Observation end of November

The therapeutic work may need to evaluate the interaction between the parents and the infant and help the mother-infant attachment and bonding. This work incorporates the evaluation of the difficulties regulating physiological sensory attentional, motor or affective processes (sleeping, feeding, toileting etc.). Gradual evaluation of these procedures optimizes the connection of mother-infant dyad (Whitetraut, 2013). This case is a power full evidence for the necessity of the physical and emotional maternal presence in NICU.

comments November

The proposal for a close caregiving privileged relationship with the mother aims to improve feeding patterns by substituting the incoherent caregiving relationship resulting from the numerous members of the NICU staff.

Infants in NICU are found in a particularly stressful situation where risking to form insecure relationships often correlate with a distorted maternal representation. Similarly, Anna has accessed a state of a rich fantasy activity and anxious projections on her infant. Anna moves in and starts to actually organize the caregiving to the infant. At this time Mary is already 5 months old. Her adaptation in the NICU environment is characterized by anxiety and seems reluctant to receive encouragement and support from the stuff. In general, people seem to differ in terms of receiving support from the nursing staff although greatly helpful. Yet interference with the staff for some parents gives the sense of being Dias affectionate themselves or incompetent. In this case Anna started her own negotiation for her parental role. That apparently is not very intuitive to her. Unboublty this was not the easiest case for the creation of the maternal identity, in fact the circumstances convinced her that she can't control the situation, nor provide her infant with safety and her nourishment is completely insufficient. And to go a little further, Anna fears that her husband or his family blame her for the child's weaknesses, yet another devaluation of her social and family

environment. She has the sense that her poor mothering has an impact to the social environment, husband and significant others. On the other hand, her staying close to the hospital offers a significant opportunity for rich clinical observation and additional contacts daily. Premature delivery increases mothers' need for social support while feeling powerlessness, loneliness and loss of social success (Meyer 1993, 1995). On top of that the limited interaction of maternal nursing and feeding magnified the sense of being bad or incompetent. "I feel completely useless, I am not a good mother" says Anna when her baby refuses the bottle.

Day 150 month 6 (December)

Mary is discharged from the NICU, After being hospitalized in the NICU for 150 days Mary is finally able to leave on December, 24th. She weighs 3.530gr. and her meals contain exclusively Infantine - high calorie formula to gain weight. The symptoms of oral aversion still afflict Mary thus the recommendation is that the family should keep contact with the follow up team of the department but the parents are not willing to follow any systematic support.

At 12 months of corrected age,

During the scheduled follow-up post-natal interview in our department, the NICU team evaluated Mary's general health status as relatively good. More specifically, although diagnosed acquiring diaphragmatic deformity in her immediate post-natal period, she rarely suffered from pneumopathies. Although the baby had developed poor feeding and bad temperament there were not reported specific incidents of deglutition disorder. Throughout the interview this narration lacked coherence and contained inconsistencies when describing their usual caregiving of the child. Due to preexisting periventricular white matter injury she seems to have acquired long term motor and cognitive deficits presenting moderate acquisition delay (limit) (speech, motor skills), physical signs of impairment. Our team stressed the importance of following a coherent multidisciplinary program including a psychotherapist, physiotherapist and consultant in order to support the developmental needs of Anna.

Relational dimensions and symptom function

The mother manifests anger within the relationship with the caring team, it appears that this traumatic motherhood and her personal devaluation are the immediate causes of her anger. How could she possibly be helped to construct solidly the early relationship of her own dyad infant-mother? How can we support her to be less defensive while she perceives danger? The infant's hospitalization had common elements with that of her late father. She was reporting that this experience was equally traumatic for her representing mourning and a threat. The repetition to cope with the medical team and the hospital environment was unbearable for her. The main issue behind this case and its resolution relied on the mother's understanding of her maternal representation and how this was part of her personal history. Anna, with her body, represented like all children, the story of her parents or even became a reincarnation of a trans generation pattern or a significant family scenario (Missonnier, 2012). Sometimes the illness or problem of a child underlines the sick extension of the mother, as diabetes in this example. Apparently, she couldn't gain the recognition required in order to become mother. This complicated and affective experience turns into a sole narcissistic wound. An echo of the heavy past that seemed to be repeated in view of the evolutionary and non-temporal dynamic of suffering, which can take a central place in the future.

Clinical interviews

The premature newborn much differs from a typical newborn and thus does not coincide with the maternal excpectation and the imaginary baby (Stern, 1983). Mothers of premature infants very often are in great difficulty and need personalized care pursuant to their degree of vulnerability. The therapeutic framework is not only a psychotherapeutic interview, but becomes mostly sessions of accompaniment, understanding, interpretation and familiarization with the medical environment and less preparation for parenthood. Professionals can reframe listening, synthesize the interview, discern desirable and useful transmissions to parents who feel lost. It seems though, that consultation with the couple, or with the mother individually emerges as a necessity since the couple really needed a person as a mediator between them and the medical team. During the first sessions, we worked on the subject of the effect of parental interaction in relation to the psycho-emotional development of the newborn. It was important to note to the mother that stress had a negative effect on the mother-infant attachment. A query must be answered: how can we possibly develop therapeutic strategies to re-introduce a disconnected distant mother to a traumatized infant lying in an incubator

and still remains the little unknown? It was essential that our meetings were more frequent. Meanwhile the generalized anxiety of the parents was expressed as devaluation toward the medical team, by continuously asking several specialists for a medical evaluation. Their internal need for security and psychic tranquility, led them unconsciously to the disqualification of the medical team, creating a cycle of devaluation between themselves, their parental role, their own infant, and the medical care provided. They strive for the reassurance that they cannot gain as parents, thus the cycle of devaluation.

For this reason, the therapeutic interventions aim to activate the inhibited maternal inclination towards the infant. The origin of Anna with rigid social beliefs and social representation was deeply wounded by the fact she couldn't acquire the ideal family to support her social survival in her community. In many cultures, a woman is considered a good mother only if she is able to give her husband a healthy son (Stern, 1983). Consultation embodied during feeding processes, bathing and diaper changing could be more appealing for the parent and be perceived as special training to follow the behavioral cues of the infant. Supporting the development of maternal care is a way for a mother to conceptualize her identity and reorganize her representation consciously and subconsciously. In the same time influences the developmental process of the newborn and facilitates the survival of the newborn. To further support our hypothesis, she was asked to respond (after providing full consent) to PPSD Questionnaire in order to acquire additional. PPSDQ is already a useful clinical auto-questionnaire able to document the full range of perinatal post-traumatic disorders. Both in research and clinical practice it is suggested that mothers acquiring a score of 19 and above need referral to therapy (Callahan, 2006). Anna acquired a score of 28. The psychopathological analysis of the disorders directed us towards a neurological cause-effect, yet it seems necessary to evaluate the oral and medical historical background of the child, all the above elements should be integrated into the lived experience and the transgenerational family history.

Myths, patterns and rules

The myth draws its strength from the traumatic effect of the real fact, the short-term usefulness of the decision, the immaturity of those who make the decisions, the inability to periodically re-examine those decisions and its growing inopportunity of relegation of pain. Whether coming from the unconscious, or remain alive and identified as catastrophic premonitions the unconscious does not have the same sense of time as our conscious life. The traumatic events of each spouse, in a couple, draw their personal history, along with disarounding myths influence the couple's attempts to find ways to share their lives and bring their children up who become co-participants in this process. This is how the new family perpetuate and shares these myths as their own; thereafter, these myths will be part of the inner identity of its members.

Myths nourish models, powerful in these interactions, through which family members interpellated and support each other, repeatedly. Models create a status of rules and dilemmas, that in turn, reinforce the myth. Rules are undesignated as hidden guidelines of acceptable behavior that preserve the system and shape the dynamics of the family (Jackson, 1968). Parents and children follow them automatically and they are more aware of the rules than the myths. Family members, in relation to the transgression of the rules, experience feelings of guilt and anguish, which can lead to disenchantment. Likewise, during the transition from the imaginary baby to the real, they express denial of hope, tension and confusion in the relationship among family members. Major emotional upheavals during life span could not support positively the coordination of infant-mother relationship. In particular the painful reality of unexpected separation and the critically preterm newborn composes a scenario that magnified the need for early intervention. Undoubtedly this life crisis induces identifications in a dramatic way while reviling major themes for the parents. Eventually, the therapeutic role is to highlight the parental psychological strangle during this time. For this reason, by redefining again the child as well as the parental identity, can prevent errors and irreparable faults. Obviously, the case of Anna is a repetition of the phenomenon of a threat of aspiration of the maternal brother. So as to reach a full diagnosis it is essential to consider the themes that emerge throughout this case. Although the child's temperament plays an important role in terms of physiopathology, Anna is part of the family history.

A summarized analysis

The purpose of our intervention is to assign strategies in order to help the mother-child dyad and minimize the impact of great prematurity (oral aversion, attachment issues, acquisition delay, behavioral difficulties).

Uncourtly we could offer a multi-level explanation. For this reason, it is important to enclose the following

1. The évaluation of the neurological deficits,
2. The maternal deprivation resulted from the extended hospitalization as well as the orality disorders
3. The enlightenment of the long transgenerational patterns of the family.
4. Strict médical

Conclusion

The infant's symptoms often escape medical logic. Sometimes, the mother remains motionless within the dysfunctional relationship with her child. She seems to prefer the dynamic change or even the alteration of the mother-child interaction being evoked by anxious or unpleasant experiences. Somehow it seems easier for a mother to identify with the opposing disease. The infantile disease gives a justifying dimension to the demanding behavior as well as to her existence. Although the food intake has turned into a photogenic procedure, it supports the aggression impulses. Persistent eating difficulties during infancy could take great connotation and it seems unavoidable for the analytic prosses not to go a little further and overcome oral fixation (Lebovici, 1983). The body of a premature hospitalized infant becomes an object of technical and medical possesses. It is largely accepted that the quality of suction, the stages of feeding development, pleasure and bucco-facial praxis are associated by the duration of assisted ventilation.

Attributing food ad version of feeding difficulties exclusively to medical factors could be a big mistake (Kreisler, 1974, 1985; Aubry, 2003). The physical separation of premature infants from their mother during the first hours creates a lack of maternal care and influences their physical development: growth retardation, psychical anorexia, associability, indifference, language delay (stereotypes and character disorders (Bowlby, 2002)). The lasting infant illness generates conflicting and anxious behaviors on behalf of the mothers (Aubry, 2003). Most of the time, family funcion changes and mothers are even experiencing depression or in a state of organized generalized anxiety. The extensive hospitalization in NICU, prematurity and the fragile health of the newborn reverses his physical cycle and evolution. In particular the establishment of the actual relation with the mother which normally takes place during the second trimester is deeply shaken (Kreisler, 1976). Infants' eating difficulties can be disqualifying for those who take care and especially for his/her mother.

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Glossary and Abbreviations

AC	Corrected Age
PB	Premature Birth
CPAP	Continuous Positive Airway Pressure - Ventilation PPC
TC	Thoracic compression
HA	Hypertension
AMF	Assisted Medical Fertilization
IVH	Intra Ventricular Hemorrhage
TPB	Threat of premature birth
PE	Pre-Eclampsia
RCIU	Intra-Uterine Growth Delay

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