Understanding Newborn Behavior & Early Relationships

The Newborn Behavioral Observations (NBO) System Handbook

by

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milestones. Finally, the NBO can be a screening tool for identification of concerning behaviors and neurological responses that were not identified in the early newborn period and that may require additional evaluation.

Use of the NBO can be tailored to virtually any environment in which the nurse encounters the family (e.g., hospital, pediatric office visit, home visit) and can be used as easily in an infant-focused pediatric visit as it can in a maternal postpartum examination or a home visit with the family. The flexibility and the applicability of the NBO across this range of environments and clinicians speak to its usefulness and ease of administration in the postpartum period.

In addition, the NBO can be tailored to highlight specific concerns or questions that parents may have. For instance, if a mother has noticed that her infant wakes easily, then there may be greater focus on the habituation, or sleep protection, items. Elements of the NBO can be used on the basis of the state that the infant is in when the examination commences. With a sleeping infant, the observation starts with the habituation items; the motor tone or activity level items can be assessed first when the observation starts with the infant in an active alert state. If the infant is crying, then the NBO can start with the consolability items. Infants who are in the quiet alert state are ready to engage in the visual (tracking) and auditory or social-interactive items. For preparation, the nurse need only carry the small NBO kit.

The benefit of performing the NBO in the presence of the parents cannot be overstated. It is by its very nature an interactive tool wherein the clinician and the parents learn about the infant’s repertoire, style, and capacities, with the added entrée into the parents’ and clinician’s learning more about parental meaning, concerns, and responses. Following is a clinical vignette illustrating the use of the NBO in a postpartum home visit by a public health nurse (PHN).

Clinical Vignette: The NBO in the Home Visit

The PHN knocked on Maria’s front door and could hear an infant crying somewhere in the house. The crying got closer, and Maria opened the door, gently bouncing against her shoulder 4-week-old Adrian, dressed in a diaper and undershirt, crying full force and flailing his arms. Maria: “Sorry. He’s just been doing this all day and most of the night.” Maria looked tired and frustrated. “Nothing seems to help him, and I’ve been holding him for hours.”

Together on the couch, the PHN and Maria talk about Adrian and Maria’s attempts to soothe and calm him. When the PHN asks what Maria has tried and what has worked, she lists a series of things that she has done to help soothe Adrian.

Maria: “I’m just done. I think it must be breast feeding. Everyone tells me to give him formula or cereal and that will help. Maybe that will do it.”
The PHN offers to do an NBO, and they place Adrian on the couch between them. For a few seconds, they watch him as he cries and moves his arms and legs actively in the air.

Clinical Comment: This strategy by the PHN models a way for Maria to be with Adrian when he is crying and allows her to watch and learn more about his distress, the behavioral messages that he is giving, his ability to manage his distress, and what he may need from his mother. By not rushing in immediately to alleviate his distress, Maria can both learn more about her son and support him in providing a wider repertoire of cues.

PHN: “Let’s see how much support he might need from you to calm himself down or whether he can even do it yet by himself.” She leans over and presents her face to Adrian, who continues to cry, and then she says softly, “Hey, what you doing? Adrian, your mommy is right here beside you. Can you calm yourself down? How you doing?”

Clinical Comment: The PHN’s carefully chosen language in administering the NBO has established implicitly that learning to calm himself is a developmental task for Adrian. She has also implied that she, the professional nurse, does not know what Adrian wants and that together, mother and nurse will explore what he can do to calm himself. This is a critical strategy that places mother and nurse in an equal partnership as they think together about Adrian and work to understand his abilities. It also has established that Adrian may not be able to do it all alone yet and may need his mother to intervene to support him as he develops this capacity. The parallel process of nurse and mother is evident.

Adrian slows his crying pattern, pauses for a moment, and looks at the PHN. Within seconds, he starts crying again. Maria says that she has seen that her voice sometimes calms him, but “just like now, he starts back up.” The PHN asks Maria to place her hand on Adrian’s belly; again, he briefly slows his crying, and then resumes. After a few seconds, the PHN asks Maria to gently bring Adrian’s hands together and let them rest in the middle of his belly. Adrian stops crying, takes several longs breaths, and then starts fussing.

Clinical Comment: This expert PHN used a very strategic approach in electing to have Maria carry out most of the elements of the consolability steps under her guidance. Being aware of Maria’s vulnerability and frustration in understanding the kind of support that Adrian needed to soothe himself, the PHN considered that if she were successful in helping Adrian soothe himself, this may undermine
Maria’s sense of competence in her mothering role. During this encounter, the PHN guided Maria through the steps that resulted in effective soothing, and Adrian’s progress became a shared success for mother and son, and the PHN could witness and affirm their achievement. This also provided Maria with multisensory information about Adrian as she felt his response with her hands, heard the quality and the nuance of his cry, and saw his behaviors while she learned implicitly about strategies for consoling him. The PHN is developing a working alliance with Maria, and she is careful not to violate the infant–parent relationship by performing the activities that might calm Adrian when his mother has been struggling with this issue.

Maria: “See, he just cannot stop. I think he cries half the day, eats a little, sleeps, then cries more. Adrian, my little man, what can I do?” The PHN notices that Maria’s affect remains warm and concerned toward Adrian and that her body movements are smooth, and she notices the amount of talking and the tone as Maria attends to Adrian. She observes the gentleness of Maria’s touch as she gathers and holds Adrian’s hands. Adrian looks briefly at Maria, and his face momentarily softens, his eyes widen, and his lips pull forward. As she and Adrian make eye contact for a moment, Maria’s face softens, too. “I love you, mijo,” she says in a noticeably gentler and more intimate tone.

Clinical Comment: Maria’s reaction to the infant during the NBO provided vital data for the nurse in her understanding of Maria’s parenting skills, responsivity to her newborn, self-regulation, and ability to engage in mutual regulation with her son. The nurse gained insight into Maria’s affect as she attended to her fussing child, and the nurse was able to see how Maria used her voice and tone in communicating to him her presence and concern. The nurse also observed Adrian’s response to his mother and Maria’s ability to notice and respond to extremely subtle cues from her young son.

PHN: “You have such a nice way with him. You just seem to know how he likes to be touched and talked to. How did you figure that out?” Maria talks about how much she loves Adrian and the little signals from him that tell her what he likes. Adrian begins crying again. Finally she says, “I figured out everything but this crying.” Her eyes fill up with tears.

Clinical Comment: In a parallel process, the skilled PHN has observed subtle and sophisticated cues that the mother exhibits, and she comments on these to
Maria in a general statement about her “way” with her son. Then, the PHN carefully positions Maria as the expert on Adrian with a question about how she accomplished this level of skill. Supported in this alliance, Maria now can share her love for and understanding of her son and her vulnerability and concern about consoling him, which is representational of all of her concerns about becoming Adrian’s mother.

The next step in the NBO consolability scale would be to pick up the infant and rock him, but the PHN believes that she observed this when she arrived, so she moves to swaddling. She asks Maria to swaddle Adrian but notices that Maria hesitates.

PHN: “What do you think about swaddling him?”

Clinical Comment: The PHN’s focus and skills allowed her to observe a very slight shift in Maria’s affect when the issue of swaddling was introduced. Rather than making an assumption about Maria’s hesitation, the PHN slows the interaction and asks what the mother thinks. Not knowing whether the hesitation meant anything at all and wondering whether there may be a cultural marker associated with this, the PHN brings respectful curiosity into their discussion and positions Maria as the expert on her experience.

Maria: “The nurse at the hospital told me to keep his hands uncovered so that he could get them to his mouth to calm himself. He hasn’t been able to do that yet, but I keep hoping.”

PHN: “Oh, that’s a good idea.” Then she suggests that they try swaddling Adrian leaving one hand out so that he can get it to his mouth and asks whether Maria has noticed which hand he tries to bring to his mouth most often. Maria has noticed this, and she swaddles Adrian leaving his right hand free, and then picks him up.

Clinical Comment: Maria’s answer to the PHN’s swaddling question has provided the nurse with great insight into Maria’s understanding of infants’ self-soothing strategies and her awareness that learning to self-soothe is an important developmental skill for Adrian. The PHN and Maria have moved into a deeper therapeutic alliance as they mutually problem-solve and develop a strategy for moving forward together. The PHN has asked another pivotal question, positioning Maria as the expert on her son, and finds that Maria has noticed which hand Adrian has tried most often to get to his mouth. The PHN now has more data about Maria’s remarkable observation skills.
Adrian takes a deep breath; his chin quivers, and he looks at his mother. She smiles: “Hey there, little man. How are you? Is that what you wanted?” He turns his head slightly and stares at his mother’s face. She cradles him and relaxes back against the couch. Mother and son look in one another’s eyes for more than a minute without saying anything. She turns to the PHN and smiles: “Look at him. Peace! His body feels so relaxed.”

PHN: “I can see how much you know about Adrian. You seemed to know that more talking or movement right now might be too much for him.” Together they talk about the kind of support that Adrian needed to calm himself and Maria’s style with him and her comfort with swaddling him in this way. The PHN talks about Adrian’s ability to learn more about himself in the coming weeks and getting better at telling his mom what he likes.

PHN: “Next time I come, I’d love to hear more about how he tells you what he wants from you.”

Clinical Comment: The PHN narrates Maria’s and Adrian’s experience and validates Maria’s skills and competence. The PHN closes the home visit with a comment about anticipating and expecting to learn more from Maria about Adrian at the next home visit. This, again, positions Maria as the expert on Adrian and the PHN as a supportive professional coming alongside the mother to support her.

In this vignette, the impact of the visit was not accidental or a prescriptive formula for a home-visit encounter. The administration of the NBO was expanded by the skill and the experience of the PHN, who used careful observation, pacing, infant-focused questions, and thoughtful, strategic decision making to enhance the effectiveness of the NBO and the efficacy and the impact of the home visit. The PHN did not arrive at Maria’s home intending to administer the NBO but rather used this tool to follow the lead of the mother and expand both her own and the mother’s understanding of Adrian’s capacities and style of communication. In a triadic session such as this, the infant became the focus from which the PHN–parent relationship gained new dimensions of respect, trust, and understanding, and what is known as the affirming matrix was expanded as the mother experienced acceptance of her infant and acknowledgment of herself in the mothering role (Rubin, 1967; Stern & Bruschweiler-Stern, 1998).

THE AFFIRMING MATRIX

In Neurons to Neighborhoods, Shonkoff and Phillips (2000) concluded that the most successful primary prevention and therapeutic interventions on behalf of the in-
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