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Denise Steibel, Nara Amália Caron & Rita Sobreira Lopes

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An observer’s intense and challenging journey observing the short life of an extremely premature baby in Neonatal Intensive Care

Denise Steibel*, Nara Amália Caron and Rita Sobreira Lopes

An extremely premature baby can teach us a lot about the depths of human nature, helping us to put words to some primitive emotional phenomena. A two and a half month observation of a very premature baby in the Neonatal Intensive Care Unit, using the Bick method of infant observation created the possibility of being in touch with the experience of the baby in the artificial environment of his incubator. Taking care of this baby was not an easy task. Not only was he born extremely premature and with major physical disabilities, but the care he also required easily turned into serious environmental impingements on him. Some vignettes taken from the observer’s written reports illustrate the intensity of her emotional experience in contact with this baby’s increasingly slender hold on life. The observer’s painstaking journey is described in detail and illustrates the difficult task of tuning into the world of an extremely premature baby and trying to make sense of it.

**Keywords:** observation in NICU; primitive emotional states; extreme prematurity; unintegration; aloneness; dying

The life of an individual is an interval between two states of unaliveness. (Winnicott, 1988a, p. 132)

Observing a baby’s normal development from birth includes having the earliest anxieties of unintegration, the primary state of helplessness and of absolute dependence all of which affect us in a visceral way. In the case of premature babies who cannot independently breathe or maintain their own body temperature and who are not able to establish an immediate physical bond with mother or father, then the impact on the observer is even greater. An extremely premature baby can teach us a lot about the depths of human nature, helping us to translate and conceptualise (to a degree) some primitive

*Corresponding author. Email: denise_steibel@hotmail.com

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emotional life phenomena. The observer, using an application of Bick’s (1964) method of infant observation, was able to be very directly in touch with the primitive emotional experiences of a baby in the two and a half months he lived in the artificial and mechanical environment of an incubator in the Neonatal Intensive Care Unit (NICU), when he should still have been in his mother’s womb.

The observations from which we shall quote all occurred in the NICU where the intensity of events was observed three times a week, every other day. The observations were written and presented to a supervision group, for discussion. In the interests of confidentiality we have changed names and have called the observed baby Henrique, and his mother, Joana.

The emotional impact on the observer of the first contact with the baby and the NICU

The observer goes into the hospital, with permission to observe in the NICU and she is informed about the birth of a baby who had been born extremely premature at 24 weeks gestation and 640 grams, and she is curious to meet him. The professional takes her to see this baby, with the intention of giving her the medical information about him. Entering the NICU for the first time is not an easy task. The babies’ size, their appearance, the loud noises, the thin line between life and death, and the NICU’s extremely invasive procedures have an intense impact on the observer (as they do on parents). The observer is open and receptive to the chaotic primitive anxieties which are inevitably present. When the observer enters the room where the baby is, she sees him and she is gripped by intense feelings described in the following vignette:

I feel hypnotized by the baby; it seems that my hearing filters out other stimuli, my body starts to feel hot and I feel my heart beat. When I experience these sensations I immediately feel anxiety, which I inevitably associate with the present sensations and the boundary between life and death, and I say to myself, ‘How strong!’ When I see him, I am impressed by his small size and his dark colour. I see a tube in his mouth, with a little secretion and I think about how hard this baby must be fighting to stay alive. I am ‘awakened’ by the doctor who brought me to see the baby, who shows me some information on the chart. (1st visit: 5 days old)

This vignette illustrates the intensity of the observer’s emotional experience in contact with this extremely premature baby. She is thrown precipitately into a primitive world of sensations and emotions. She feels skinless, with no preparation for that impact. The invasion was so intense that she temporarily suspended her contact with external reality. This intense experience lived by the observer makes us think that perhaps the observer’s first contact with this baby might give us an idea of how Henrique’s first contact with the outside world might have felt to him. Through deep identification with the baby, it was possible with further reflection for the observer to transform the intensity of the emotions of that moment and to give them meaning.
After this unexpected emotional contact with the baby, the doctor suggested to the observer that perhaps she should choose another baby to observe; this baby’s clinical condition was very serious, and he might not survive. The doctor also said that the NICU team’s task was to adapt to Henrique’s needs, making interventions only when necessary, since anything else might be too much for him. The observer knew it would not be an easy journey, that seemed likely to end in the baby’s death, but the staff also indicated the very slim possibility that he might survive.

The task of both observer and analyst is to be prepared to be emotionally available for a relationship where they do not know what to expect. They must be aware that during the observation or during analytic treatment, they do not know how it is going to end; there is certainly no guarantee of success. The only thing they can offer is their body and mind, and their availability to receive whatever the patient or the baby communicates to them. We highlight the importance of this attitude as we consider that in the observation of Henrique it would have been very easy for the observer to move on, as the team would do later, in an ambivalent way. Winnicott would wisely point out:

Let us also bear in mind that by the legitimate method of careful choice of case we may and usually do avoid meeting aspects of human nature that must take us beyond our technical equipment. (Winnicott, 1958, p. 278)

We firmly believe that the infant observation method is a fundamental tool for refining ‘our technical equipment’, enhancing emotional receptiveness to primitive states of mind such as that of an extremely premature baby.

The observer felt so pulled-in by the first contact with Henrique that she felt she was willing to go ahead and to observe him in his journey and wait to see where he would take her, tolerating the unknown. So, the observer contacts Henrique’s mother to discuss the observation and to obtain permission. As she hears what is proposed, she accepts immediately. Henrique’s clinical notes, later affirmed by his mother indicate that his birth was premature because his mother had an infection in her cervix, which had been diagnosed quite late by the doctors. He was Joana’s firstborn and had serious clinical complications. The doctor reported that due to his extreme prematurity, the first challenge had been to intubate him; they feared his lungs might not have sufficient tissue to withstand the pressure of the air intake. Henrique won his first battle, a machine could breathe for him and he was taken to the NICU, where he declined physically.

**Mother, infant and observer fighting for life**

After having set up the observation with Joana, Henrique’s mother, at fixed times and on alternate days, three times a week, the observer began the formally agreed observation. The first scheduled observation occurred when mother was not there, again leaving the observer alone, in contact with this baby. During the
observation she felt it was very difficult to connect to Henrique who seemed so clearly not ready to be in the external world:

I feel like going away, I do not know if it is because his mother is not here, or if it is because the environment is very distressing. There are other babies and sometimes monitors or alarms trigger noises and perhaps because I am not in a familiar place, I immediately feel very concerned. (1st observation: 1 week old)

The infant observation setting, with fixed days, and time, as well as weekly seminar discussion, allowed the observer to manage her role and to use her previous experience as well as the support to help her to tolerate the anxieties and to be able to transform it into some understanding of what was happening. The initial discomfort and pain in such a chaotic environment became more bearable for the observer, who had felt the barrier of the incubator glass and she could begin actually to look at Henrique. She disconnected from the external environment and began to connect with him and to empathise with some of his fragilities, and to bear her awareness of the ventilator which breathed for him.

In the second observation the observer is welcomed by seeing mother watching her son. Joana announces, ‘Today he is in this new incubator, getting a different type of heat’. Indeed, in mother’s presence, the observation’s ‘temperature’ feels different. When the observer arrives, the mother seems to sense her ignorance and curiosity. She shows the observer the clinical notes and formally introduces Henrique to her. She also explains how the baby’s monitors work, which are the most appropriate levels for his heartbeat and air saturation, and about the functions of each tube connected to his body. (2nd observation: 1 week and 2 days)

Gradually, this clinical presentation of Henrique fades, giving some space for silence, being together, a new experience that initially seems to surprise his mother, but that somehow affects her and seems to create a strong connection to the observer. Through silent communication, by observing the baby, the observer invited mother to experience the Henrique she had got to know by other means. Through this silence and the observer’s ability to let herself go where the observation would take her, sensations, thoughts and imaginings could circulate. The observer also acted as a model for the mother, who was present in this second observation and could share intense moments with her. For example, in the following vignette:

We are in silence for a few moments, and I’m observing Henrique’s skin and noticing how different it is, how dry it looks, looking even wrinkled. I remember the movie Benjamin Button, in which he is born, a baby, but in an old man’s body, with wrinkles and weaknesses. I believe that it is not only Henrique’s skin which brings this mental association with an elderly man, but also the closeness to death. Again, I feel that this baby must be struggling hard to survive. When ‘I wake up’ from my musing, I realize I am caressing my arm, as if I were comforting myself. I look to the side, and
I see that the mother is cradling herself, with her eyes fixed on Henrique, as if cradling him, but without him in her arms. I am impressed with the scene that connects us. (2nd observation: 1 week and 2 days)

It is noteworthy in this observation that a space develops; an area in which mother and observer can share experiences and connect in a way that goes far beyond the conscious level, more like unconscious–to–unconscious communication.

The observer’s receptive attitude plays an important role in creating this experience of mutuality (Winnicott, 1969/1989). At this moment, the mother-infant, observer-infant pair was in ‘…a place where verbalization has no meaning,’ (Winnicott, 1968/1988b, p. 92), where external reality does not interfere and, in the subjective world a developing space is shared.

There is a connection between me, Joana and Henrique, that helps emotions circulate. This circulation relieves us. I associate it with haemodialysis, which filters the blood, through circulation. (2nd observation: 1 week and 2 days)

Caring for Henrique is not an easy task. Besides the fact that he was born extremely premature and with major physical disabilities, the care provided to him easily turns into serious physical impingement. For example when he was born, a nurse cleaned him with iodine alcohol; his skin was so thin that it was burnt by this standard procedure, creating a wound that became a gateway to bacterial infection.

His mother’s presence also seemed to cause an emotional overload for him. Sometimes, during the observation, Henrique’s oxygen saturation would drop when his mother approached. Joana felt this and would leave the NICU, and Henrique would stabilise again. She did not know whether to stay near or far; the observer watched her as she came and went from the NICU, being close and then very distant from her son.

In one of the observations, Henrique needed to be moved to another incubator, a moment in which major failures were witnessed, for instance when the staff changed the mechanical ventilator and he was without oxygen for a long period.

The nurse starts swapping some tubes; she disconnects his monitor and then the breathing tube. I get worried. She holds him in her hands, and I notice his belly is not rising and falling. It is very distressing. I feel that my own breathing rhythm changes. Then, a tube gets stuck to the incubator, preventing the nurse from completing the procedure. They give up the attempt and connect the air again. I’m relieved as his belly moves again. (2nd observation: 1 week and 2 days)

This experience was so dangerous that Henrique took time to recover physically for the next few days. In this vulnerable condition, he needed to deal with repeated environmental failures. The mother and the observer, each linked closely to Henrique, also felt the consequences of these failures and imbalances and had to take time slowly to gather themselves together as well:
Joana seems relieved to be near him, to talk to him. More than using words, she observes him; monitors him. I, sometimes, feel like comforting her in some way, but I think that words lack meaning in this situation. I stay there. He seems to be slowly stabilising. (2nd observation: 1 week and 2 days)

Once again the mother–observer couple had to be strong enough to recover from Henrique’s inability to breathe for himself, which affected them both physically and emotionally. Gradually, together, they could breathe again, stabilise and recover the mother–infant–observer balance – a shared recovery. The observer also felt skinless in this raw contact with Henrique. The description of her experience shared with him may have helped to contain and to transform what he had gone through which was somehow communicated to her. In one of the observations, Henrique looked very unstable, and such instability acted directly on the observer’s body:

I start to have bodily sensations which increase gradually; I get hot and have stomach contractions; my heartbeat seems weak. I am amazed at the intensity of these feelings to the point that I wonder if they are due to my contact with Henrique or whether they are caused by something missing in my body. I check if my own basic needs have been met; have I eaten, drunk slept, and I realize that, in fact, my body is responding to Henrique’s physical and emotional state here. The feelings continue to intensify, and I begin to sweat and my feet start to tingle. I realise, that my blood pressure is probably dropping. I feel the need to get away from Henrique and sit down, to avoid collapsing and to try to recover. I find a chair, sit back and take a deep breath of the fresh air coming in through the window. I catch a glimpse of Henrique’s monitor and his saturation is above 90%. I tell myself, with a certain relief, ‘Now that I’m feeling bad, you are going to get better.’ (3rd observation: 1 week and 4 days old)

Through an intense connection with Henrique the observer’s skin/body/psyche contains and transforms Henrique’s terrible experiences and his own fragile physical and psychic skin. In supervision we mention that the observer offers her own body as a monitor identifying with the baby’s helplessness, and feeling in her own body the discomfort, tension and suffering of a baby who is constantly invaded and manipulated. It is worth remembering here the observer’s own wish to sustain Henrique’s life which was certainly present at the beginning and had to be worked through during the observations and their discussion in the supervision group.

To witness such human suffering and the constant risk of death in such a small baby provokes intense emotional overload and affects others who are close in a very primitive way. Reactions in these situations can vary. Some sensations are interpreted by the observer’s own experience that at times includes irritation with the team, feeling an intense desire to ‘blame’ someone for the baby’s suffering. In such a way she is able to understand the interplay of projections often seen in teams and also in parents in this and in other extreme situations.
Henrique’s clinical condition worsens; he remained motionless inside the incubator. This created an atmosphere of emptiness and deadliness during the observation.

I gradually start to feel a mixture of sleep and boredom (…) I feel my eyes getting heavier. (5th observation: 2 weeks and 2 days)

In the face of this absence

I wish someone would arrive to stay with us, perhaps a third person to pull me away or to share this sleepiness that is invading me. (5th observation, 2 weeks and 2 days)

The presence of death is clear. In line with what the observer is feeling, the environment seems to be affected by these deadly states without being able to be consciously aware of them.

In a standard procedure to check Henrique’s vital signs, the tube that connects his body to the respirator becomes disconnected leaving Henrique without air for a few seconds. Henrique, who is motionless, suddenly contracts his belly. When the nurse speedily connects the air tube again, he comes out of his deadly state, and starts being agitated and lively again. (5th observation: 2 weeks and 2 days)

It is clear that the observer’s feeling of wanting to get rid of the deadly experiences with the baby could also be seen in the nurse who wakes him up resuscitating him quickly. The resonance of what Henrique communicates through projection is so intense that it seems to invade whoever is near him.

The observer is often left alone with Henrique; very few people manage to stay with him. The team goes through standard procedures and goes away; the mother is in and out of the NICU. The challenge of being close to this baby seemed to be translated into the observer’s physical sensations:

I feel very hot. I realize that this heat is different from ordinary heat; it is as if it came from my stomach and as if I am enveloped in thermal clothes that do not allow the air to circulate. I feel all muffled up. My face sweats and I have to wipe it again and again. Then, I start to feel cold in my body’s extremities, as if I were sweating cold, while I still feel hot in my chest. Joana says, ‘You see; his saturation is low again.’ (6th observation: 2 weeks and 4 days)

Henrique begins to show signs of necrosis on his toes, which reminds the observer of the strong chills she felt in her extremities. The massive identification that she feels with Henrique is striking; there is a state of baby–observer indiscrimination, an osmotic exchange that needs time to be digested and understood. A cyclical oscillation can be observed of approaching, getting filled up with emotions, losing her sense of identity and then slowly finding it again. This movement allows for the observer in each observation to come a little closer to Henrique and his experiences. The observer feels all alone because she does...
not feel that Henrique is a partner in this communication; on the contrary, he
seems more and more to be saying goodbye to life.

Henrique’s skin looks withered, and the supervision group highlights the
absence of life force, of vitality, in his body. The observer’s wish seems to be to
fill this increasingly floppy body with lively shape. He seems to be fading away:

I feel like putting my hand inside the incubator and straightening his skin because it
looks like a twisted towel. It is awful to see a baby falling to pieces. His back looks like
his front. I wish to gather together this baby and make him whole. Initially I think of
manually arranging him, but I realize that my touch would be much too rough; he is
so delicate. I want to wrap him, to get him integrated somehow, to protect him
physically but not by touching. My thoughts meet my bodily experience. Internally
I feel my muscles contracting gradually. The result of this mixing up of body and
mind – a nameless emotional experience – is the emergence of a feeling that I want to
hold this baby inside my womb. What better place would there be to continue his
intrauterine development, if not inside a womb? (9th observation: 3 weeks and 4 days)

To be in contact with such suffering and to witness a baby gradually losing his
bodily functions is painful and extremely difficult to bear.

It is a difficult observation to report, because I find it difficult to recall facts, but I have
remnants of feelings and it is a challenge to put them on paper in temporal sequence.
(9th observation: 3 weeks and 4 days)

These experiences are so hard to remember that the idea of seeing Henrique as a
baby who seems to be decomposing while he is still alive could only be put into
words after the observer presents the observation to the supervision group. She
did not write anything down after the previous observation. The intrusion and
violent force of such raw experiences made her temporarily forget them. A
posteriori, with the help of the containment of the group, the experience was
recovered and put into words.

As she became used to the NICU environment the observer sometimes
came a bit distant, and indifferent to the tense atmosphere, as if she needed
some form of protection,

I arrive at the hospital and automatically direct myself to the NICU. I begin to wash
my hands and realize I have not looked into the room as usual. I am surprised at my
excessive distraction and ‘disregard’ on my arrival. (10th observation, 4 weeks old)

Joana is next to Henrique, and the suffering is visible on her face when she sees
him in such pain and terror. Joana also shows her own tiredness and lack of
strength.

Joana looks a bit tired and unresponsive. She tries to interact with the staff, but the
most one can read in her expression is a smile without much life. But she is there (…) she
gets up and says, ‘He is moving like that because he is in pain’. She cleans her
hands with alcohol, opens the incubator, and puts her hand on Henrique’s little back.
Her hand is too big, close to Henrique’s and she seems not to know how to handle him; he seems to be too delicate. I have the feeling she is bearing the weight of her hand in order that it should not be too heavy for him, leaving me in doubt about whether she is actually touching him or just putting her hand close to his body. Henrique keeps moving and she says, in a pained voice, ‘It is as painful as hell.’ She places the tip of her finger in Henrique’s little hand and keeps it there. I realize that Henrique is slowly calming down. However, I notice his terrified face. It reminds me of Munch’s ‘The Scream.’ (Edvard Munch, 1893) (10th observation, 4 weeks old)

Mother was able to stay longer for a few observations, especially when she was able to use the observer. She and the observer took turns in expressing their ambivalent feelings about Henrique. When the observer felt hopeful, Joana looked worried and pessimistic. On the other hand, when the observer felt hopeless, perceiving the baby’s fragility in a more realistic way, Joana seemed to be more optimistic. In the supervision group it was possible to understand the dissociation that happened between mother and observer. It was like a seesaw that allowed them to swing between thoughts of life and death.

As time passes, it seems a challenge to find a rhythm between baby and mother as well as between the baby and the observer, suggesting a major lack of continuity. It gets harder for each of them to identify with Henrique. The mother’s hand near him, is too big. There is a major disconnection. However, in the presence of Joana and the observer, there were still be rhythmic moments which felt more natural and easy:

Joana is by my side looking at him, she is quiet and so am I. I see my foot moving to the rhythm of the respirator; it’s as if I have a pedal under my foot that I am pushing with every breath, pumping air into his lungs. (11th observation: 4 weeks and 2 days)

**Observer and infant experiencing death**

Around the 15th observation, when Henrique is 1 month and 1 week old, Joana gradually withdraws from the NICU; 1 day she asks for a priest to baptise Henrique. From then on, she keeps a greater distance from her baby, often phoning the hospital from home instead of coming in. Henrique’s clinical condition worsens dramatically. He is losing his basic functions, the medication no longer helps and since his blood is not circulating fully he develops necrosis. Witnessing this slow ‘decomposition’ of her baby becomes impossible for Joana.

The observations become increasingly difficult and heavy. Henrique has many clinical complications and feels a lot of pain. An hourly sedative keeps him in a state of inertia and the situation worsens:

I gradually feel absent and it is very difficult to observe him. Sometimes I feel numb, looking at Henrique with my eyes, but not really seeing him. There is a moment when my vision goes out of focus to such an extent I cannot see him through the incubator
glass. It is terribly hard to remain in this empty state, without sensory experiences or coherent thoughts to guide me. (13th observation: 1 month and 4 days)

These feelings also seem to reflect Henrique’s absence; however, even when he is asleep, the observation is not entirely empty. The reports show that while parts of Henrique’s body have already died, there is still a tiny part of him that clings to life, and appears in a few brief moments:

Henrique opens his eyes less often. My own eyes feel heavy. I rehearse the closing of my eyes when he closes his. I think about a mirror reflecting his sleepy movements, his pain or his stillness. I imagine the two of us playing hide and seek, because after closing his eyes for some time, he opens them and seems to find my eyes looking at him. (15th observation: 1 month, 1 week and 1 day)

The observations when mother was not there were marked by a feeling of emptiness, and some kind of ‘tranquillity’:

I do not seem to remember anything specific that has happened or has come to my mind. Only that I was there with him. I remember that at times I felt sleepy, and also that I enjoyed a nap there by his side (...) my feeling was that I was present there, but on another level. (18th observation: 1 month, 2 weeks and 1 day)

The rhythm of the observations is getting increasingly difficult, as if they are together ‘swimming against the current’. However, it is amazing in the midst of such deathliness and physical fragility this baby still fights to be connected with the world.

He rolls his eyes, looking up and down. He keeps opening and closing them as if he is trying to look at something, but it is as if he cannot see anything there and he closes his eyes again. (20th observation: 1 month, 2 weeks and 6 days)

The observer also faces the task of fighting against her own sleepiness and heavy eyelids, expressing the extreme difficulty of keeping in touch with such suffering. There are some special moments of observer–baby nonverbal communication:

At some points we find each other again. Henrique sometimes seems to me to show relief on his face, which I feel is shown spontaneously on my face too. Sometimes he seems to be in agony and I feel the change in my facial expression. We keep this imitation game that oscillates between pain to calm. I feel a strong impulse to close my heavy eyes, but I also wish to remain there in contact with him. (20th observation: 1 month, 2 weeks and 6 days old)

Even through all this, it is amazing how Henrique, who is slowly fading, is still there.

When I see the black of his eyes through a small chink, I want to cry. He wrinkles his forehead and I feel I am encouraging him to cry, to kick, because all of that was too much for him. (26th observation: 2 months and 4 days old)
At this time, the observer is invaded by physical sensations beyond her control:

My nose starts to drip and I start sniffing. I immediately imagine people will think I am crying. In fact I am having an allergic reaction. I have to leave the room to blow my nose and wash my hands again. I worry about contaminating Henrique with my sneezing. (26th observation, 2 months and 4 days old)

The bond between the observer and the baby is strong. The observer feels as if they are both skinless and exposed so that their physical symptoms and their feelings seem easily to infect the other. The observer’s body’s allergic reactions seems to be an involuntary response to something invading her to which she reacts physically; perhaps a raw contact with death.

Sometimes the observer wishes this baby would give up, while at other times she wishes him to survive no matter how. This seems to be similar to the NICU machines whose only function is to imitate life-giving function, whatever the cost. Henrique’s monitor says he is stable, it is not beeping anymore. For some babies this would be a good sign, that he is stable and getting better. However, looking at Henrique’s situation, we know that this stillness is closer to death than to life. Henrique’s body is now far from a healthy homeostasis; the machine indicates that he is stable and his lungs are saturated, but there is deadly inertia; a gradual withdrawal. The observations become something like a nameless terror:

The weight of death seemed to be there in his open eyes, it is awful to watch. I do not know what to say; the nurse comes back and cleans his mouth. The scene reminds me of boxers being cleaned up between rounds, preparing to continue to fight. Henrique is unstable, his chest is filled with strong air coming in, and I can see his heart beating (...). My mind is filled with his death and I imagine meeting his mother on Wednesday so we can say goodbye to him together. Sitting down, I am staring at him, swinging my legs and singing a melody in my head that I am also humming aloud. It seems that we are rocking. At this moment, I realise Henrique is quietening, calming. (28th observation: 2 months, 1 week and 2 days)

The struggle between life and death is coming to an end; Henrique is dying. In the penultimate observation, the observer attempts a last contact with Joana, unsuccessfully. Joana apologises for her absence, and the observer reassures her saying she understands the reason. The observer feels helpless as if she should be able to give life to the baby in some way. The last observation takes place at Christmas:

Henrique, sleeping, disconnects from the outside world, and I, as I watch him, disconnect too. (30th observation: 2 months, 1 week and 6 days old)

The observer struggled to write up the observation; she had no strength to do it. Henrique died a few hours after the end of that 30th observation, just before Christmas. On Christmas Eve the parents, who had not visited the NICU for
some time but kept in touch through daily phone calls, came into the hospital to see him.

**Final considerations**

Connecting to a baby who has not been able to connect to life is extremely difficult. The beginning and end of life are mixed together with feelings of dread and longing for life, sometimes at any cost. For Winnicott (1988a), the human being’s primary state of being is that of unaliveness, in which:

> aloneness is a fact, long before dependence is encountered. (p. 132)

For him, this original condition – the first death – colours the idea we have of ultimate death. In Winnicott’s words:

> The life of an individual is an interval between two states of unaliveness. (Winnicott, 1988a, p. 132)

One has to question whether Henrique was able really to come out of the original state of unaliveness. His experiences seemed to flood those who were physically and emotionally close to him. He could receive little in terms of human care because it so easily became an intrusion which he found physically intolerable. Medical care, for example, was so invasive that his thin skin would develop burns because it was too sensitive to be physically touched.

His mother could do little to help him and mother and baby could not live a real experience of mutuality (Winnicott, 1969/1989), the first form of human communication. Henrique lacked the minimum physical conditions for the establishment of a physical as well as a mental partnership with her. The mother–observer pair shared moments of intense communication without words, being able to come closer at times. But this was so demanding and painful for Henrique’s mother since her emotional closeness brought her into contact with the fact that her baby was not going to live. It is not at all surprising that she left before his end.

During the period that Henrique lived, the observer’s body and mind seemed at times to be able to take in some of his overwhelming physical and mental states. These sensations found a container in the observer who was in her turn contained by the supervision group. The observer herself was often overwhelmed and often physically exhausted. This enabled her at times to be in touch with some of what he went through. The vividness with which these feelings were felt in the observer’s body, as she found herself struggling with her own basic bodily functions, blood pressure, temperature, heart rate, provided an indication of the almost impossible task of holding on to life for Henrique.

Winnicott explains:

> the infant that we know as a human unit, safe in the womb, is not yet a unit in terms of emotional development. (Winnicott, 1988c, p. 116)
The baby needs to go a long way in order to achieve integration. Minimum physical and emotional conditions are necessary in him, in addition to an environment that will help him gather himself together to become a whole. This was simply not possible for Henrique. He was too ill and too premature.

With Henrique, we discovered a primitive world hardly ever experienced so directly before – of unaliveness, aloneness, unintegration, with a lack of contours, and mostly, of death. The observer could feel in her own skin the absence of the minimum conditions to sustain life in this extremely premature baby. She could only open herself to this experience because she had had a previous experience of ordinary infant observation, had a personal analysis that enabled her to be more in touch with primitive aspects of human nature; she had a theoretical body of knowledge with which to conceptualise primitive emotional development, and, most especially, she had a supporting team in her supervision group, ready to support her, to share the intense and painful experiences she had been through, and to think with her about how her experience might relate to that of this tiny, premature, sick infant.

Esther Bick (1964) highlighted the importance, for the analyst in training, of a training in infant observation, as a way of enabling a greater capacity to be in touch with patients. Infant observation encourages the development of receptivity and containment, essential for this work. Infant observation also sometimes requires observers to delve into the depths of their own experiences and anxieties.

For some observers, the observation itself, writing it up and presenting the written account enhances the capacity to be in touch with the other. It can also, of course, enable the better observation of the countertransference which is so helpful along with the tracking of the transference, in understanding the patient’s non-verbal experience. It also requires that the observer overcomes or works through her own resistance to exposure to painful and frightening, primitive experiences and knows that she can be open to them without fear of getting lost. The method offers the opportunity for the observer, and later the analyst, to be able to monitor her own feelings, sometimes including physical sensations, and to understand that they can often enhance the understanding of the baby and his environment or, of the most primitive, preverbal levels of the patient’s life.

Infant observation is a great teacher for the prospective analyst who can become more open to primitive communication projected by the other, even when it temporarily creates within the analyst an experience of losing who they are and what belongs to them. Henrique’s observer at times lost herself in his suffering. With the support of others she slowly came to feel that she understood some of what he was going through. Henrique’s short life taught all involved a great deal, and we hope that this learning can serve as seeds for other thoughts and knowledge about early emotional life, in ‘a place where verbalization has no meaning’ (Winnicott, 1968/1988b, p. 91).

It is clear to us how this experience can modify and enrich the analyst and contribute to analytic work. It took 4 years from the completion of the
observation for this paper to be written. The metabolisation of Henrique’s death took a lot of working through before it could be translated into a paper. Henrique taught us how small we are in the face of death. We do not have the power to give life, neither to take it away. The observer’s care, mother’s love and the team’s effort were certainly not enough and this is a reality that needs to be discussed further since it is such an attack on our deepest narcissism.

This has led us to wonder about the painful position of doctors, who are not able to predict with complete accuracy which babies will live and which will die. They are left with the painful task of witnessing a baby like Henrique suffering for so long in the NICU as he held on to life. Sometimes understanding the precarious and painful physical situation of some extremely premature babies leads to thought of their right to die sooner. It is difficult in the face of the pleading of some parents, and advances in medical technology, to accept that in some cases we are impotent in the face of extreme prematurity and major clinical complications. Accepting limitations is very difficult and it seems paradoxical to write that impotence enables us to grow because it is the impotence imposed on us by reality. At the end of his life, Winnicott, (1984) described the analyst’s painful process of ‘growing downwards’:

A great deal of growing is growing downwards. If I live long enough I hope I may dwindle and become small enough to get through the little hole called dying. (p. 190)

Note
1. The observer was taking part in a major research project involving the university and the hospital, aiming at studying premature babies, their parents and the NICU environment. At this point the project had already been approved by the university and hospital’s research ethics committees. Informed consent was also given by the baby’s parents.

References
