Babies of the modern world

Eve was still a very small patient, a small egg, when she was the object of the reproductive biologist who took care of IVF at the moment of her conception. “The biologist of procreation,” says Jacques Testart, “does not have the passion for the child. The egg is his object, and to know it even better, he cannot fall in love with one or another of these rudimentary, colorless, and tasteless beings.”[1]

A few months later, when Eve was born prematurely, the neonatal resuscitation team took charge of her. Twenty-five weeks and 750 grams, ten years earlier, the birth would have been considered a miscarriage. Today, she was the object of intensive care by doctors who, with the help of sophisticated machinery and cutting-edge technology, tried to keep her alive. While parents dream of the wonderful baby, biologists dream of “beautiful regular embryos that multiply the number of their blastomeres in time,”[2] and the resuscitators of a good Pco2, a hyaline membrane disease or an avoided or cured enterocolitis.

For their part, the new «psys», these other scientists of the modern world, dream of a good “adaptation” between mothers and children, of the connection maintained, “of successful attunement.” The “cure” can be evaluated, measured, filmed, and scientifically validated.

First, it must be noted that the scientist’s dream weakens a parent’s ability to dream. How will this child be? What will be his games, his joys, his sorrows? It's sometimes down to the first name that parents can't imagine. The possibility of daydreaming

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[1] Jacques Testart, préface à *La passion de l’enfant*, Paris, Denoël, coll. Médiation, 2001, p. 13.

[2] Jacques Testart, *op. cit.*, p. 11.

and that of identifying oneself with the child are suspended to a single question: is the baby viable?

Eve's mother, entering the service at a moment when the doctors had gathered around the incubator, could only say one thing, timidly, while backing into a corner of the room: "Pretend I'm not here." It is true that since the beginning of this story, the baby was not deprived of care. The baby, conceived on the outside of the mother, continued to grow without her, outside her womb. What she was asked to do was not disturb the doctors in their work. "I don't feel like I gave birth," she said, "when, at the entrance to the service, I am asked: "Are You Eve's mother?", I'm amazed for a moment, I never know what to say." This astonishment also appears when we get this mother to talk about her daughter. Of this baby, she knows nothing. A kind of childbirth under a reverse X where the X would no longer be the mother, but the child. Something of parentage also seems to have changed. "About her," tirelessly repeats Eve's mother, "about her, I have nothing to say." How, indeed, to suppose a subject in a baby and address oneself to him when he has become such an object of medicine?

When an analyst goes into intensive care, without measurement tools, without cameras, without graphs, and without statistics, he can only try to hear what's at stake for the parents, he can only acknowledge the effects of words on the babies' bodies and also the effects of his listening, of his presence, of the effects of transference on the parents and doctors.

How is the psyche of a baby constituted? How can we understand that with the same birth data, the same care, the same weight, and the same term, one child survives, the other dies?

And if he doesn't die, how do we account for the current statistics, which show a very high percentage of psychosis, autism, and hyperactivity, among "premature babies" even when they don't have neurological sequelae?

Winnicott has a reassuring response for neonatal teams: "A baby doesn't exist." But the relief is short-lived, when we explain to them what Winnicott meant. A baby does not exist, but the Mother-Baby couple does exist, and the center of gravity of being is located in what is formed by this couple, in a between-the-two that is not without evoking the transitional space. Therefore, if we want to revive the baby and give him a chance "to be" it will be necessary that the department also takes care of the mother, which complicates the work of intensive care a lot.

For Winnicott, the baby constantly has experiences which he does not understand but memorizes. Already in utero, from the fourth month of pregnancy, he receives some diverse sensory information, then at childbirth and in the first days of life, whether it is full-term or born prematurely. The more premature it is, the more difficult the information will be to decode.

Winnicott shows us how the baby that does not exist by itself is made, one could say, in the answer that his mother, or the person who cares for him, brings to the various painful discomforts that his body gives him and that have no meaning for the baby. Depending on the answers given, a sense of security or insecurity emerges. To be secure and grow, it will be necessary for the mother to adapt to her baby's bodily needs.

This ability of mothers to adapt, Winnicott speaks of it as a "disease," a good disease from which the mother suffers when everything is going well, when the mother

feel sufficiently reassured, sufficiently supported. They can then give the child the feeling of existence. The extreme fragility of premature babies requires, in order for a feeling of safety to take hold, even more presence and appropriate responses.

If one does not take into account these needs for reassurance, if the mother's response is absent or too inconsistent, the baby sinks into terrible despair. The word anguish is too weak, said Winnicott. The infant's distress is of the same nature as that underlying panic. It is a defense against extreme psychic pain. To this extreme pain Winnicott gives the name "primitive agony," it thus sums up what the baby feels when such anguishes arise; if his mother does not sense it, if she can not identify with him, he then feels says Winnicott the feeling of: "Going to pieces, making an endless fall, dying, dying, dying, losing all hope of seeing contact re-established."[3]

Growing up, the baby will carry in him the memory of this lived catastrophe; the trace of this threat of annihilation. Winnicott, shows us the distress of the baby, when it is not carried, when the mother's "holding" is made impossible. In incubators, the risk is great for the baby. How to avoid this "primitive agony"? The physical pain tied to psychic pain is further increased by the measures taken for resuscitation. How to give the baby the response that he is waiting for?

Mothers who have just given birth to a child who is then immediately taken away from them because the doctors think it is in danger find themselves totally submerged by a sense of guilt so violent that all their bearings are turned upside down.

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[3] D.W. Winnicott « le bébé et sa mère » Payot p.138.

Time stops and the rhythm of the days are only marked by weighing the baby who continues its pregnancy without them in an incubator “that incubates” the child they have not been able to sustain in their place.

Most often mothers can't look at this child, can’t talk to him, or give him a name.

The possibility of mother libidinally investing her baby suffers. How to put this baby in an ideal place where "phallicization" will be possible? How can this child, so skinny, so suffering, create a mother?

A premature child does not resemble for the mother ”His majesty the baby" about which Sigmund Freud spoke. She does not recognize herself in this child who can not recognize itself in her.

A broken mirror, an impossible dream; illusion and dream collide with the violence of the real, and the child risks only being reduced to this pure real if nothing of the symbolic has allowed the phallicization of the baby. If the mother's gaze turns away from the child, if the child too weak and far away does not give the mother the feeling that he is interested in her, the investment of love between them becomes problematic and the baby has nothing more to hang on to to make himself.

Some of these babies withdraw into themselves, they no longer communicate. Others, when they survive, become hyperactive, sometimes hyper-mature; trying to protect the mother, they care for her by being hyper-demanding, by being very communicative if she has trouble communicating. But they can also become very wise to reassure her and to engage her narcissistically; or else they can fall ill all the time and by gaining attention by their physical symptoms, demand we look after them and their mothers, thereby caring for her by proxy.

Of course the mothers of these babies between life and death are fragile. How can she invest a child that the mother feels is monstrous and persecuting, a child that signifies for her helplessness and failure?

She is behind the windows of the service, behind the windows of the incubators, so many mirrors that do not reflect anything; mothers find it difficult to look at a child who does not return anything to them of their own image. Working with mothers is always a work of mourning, loss, and separation. It is when they can symbolize lack that it becomes easier for them to unstick the child from the horror of the real and project on him a possible future.

From week to week, the team which renounces to put itself in the place of the good mother, as “omnipotent,” as the one who knows how to make the child live, questions the mother, the real one, about what she feels: "you who know him better than anyone, how do you find him this morning? Help us to understand him, that is, to know what is good for him.” This state of mind is not so easy to put in place in a medical department, where a priori, knowledge ought to be on the side of the doctors. Yet, as Winnicott points out, “mothers have a vision that surpasses what lies before their eyes, while scientists only see what has already been demonstrated.”[4] This vision of things is given to them, when primary maternal concern is possible. It is, states Winnicott: “the ability to identify with her baby as no machine can, which no teaching can transmit.”

To allow mothers this quality, the function of the team will initially be to separate the child from the mother. Contrary to popular belief, it is not as first so much a matter

[4] Winnicott « de la pédiatrie à la psychanalyse » Payot p.58.

of maintaining a connection but allowing a cut. Everything happens, indeed, as if the birth had not yet taken place. To repeat: the separation is canceled. It is difficult for a mother in a resuscitation unit to suffer from baby blues, or from primary maternal concern. In order for "birth" to be possible, the service will have to find itself in the position of the third, the separator. Resuscitating the baby at the same time as its desire to live.

It is necessary for us to get mothers to think that if their child is alive, they have something to do with it. Most of the women we received in the service would not have been mothers without the advances of science. Their babies would not have lived and they know better than anyone else who is the bearer of death.

“In the service, they gave him life,” a mother told me “I didn't have to go near him, I could only give him death.”

The hospital that comes to make the third can protect the mother from this child, and the child of this mother, absorbing the murderous violence of their fantasm. It is on the fantasm that we will have to work.

Our belief today is that hospitalization is not necessarily a source of psychological complications for the baby, but can on the contrary allow this time of working on the fantasm, it is in this that the role of the service is essential.

The baby is not a subject at birth, and still less a person. Therefore, if it's important that we consider him as a person, it doesn't mean that he is one. In order that he becomes one, it will first be necessary, as Alain Vanier says, that we suppose the baby is a subject. The subject is first in the Other, it is in the mother or the one who cares for him, those who has a body and speak to him; those who feel and lend to the baby

some emotions, some joys, some sorrows; the one who can think that he is warm or cold or perhaps hungry.

It is because an Other can experience this baby as interesting and existing for it, that the baby, in turn, knows that he exists. To put it differently, we can also say that it is the baby's way of being to be the object of the *jouissance* of the Other. Without that, it does not exist. In becoming a subject, it loses its being, since if everything goes well, a third performs a separation by prohibiting this enjoyment. This is what will bring him the opportunity to desire. He will be divided, and meaning can be given to the world the baby finds himself. But the baby will keep the nostalgia for this lost being, and will be constantly looking for the object that could give him back this being. He will use the fantasm to try to remake himself. It is only by refinding the object he was for the Other that he will be able to separate himself from it and conquer a little freedom. It is the quest for this object, its retrieval and its loss that we recover in the movement of an analytical cure. But what about when parents are prevented from gazing at the cradle, and the child is only the object of the medical gaze? Can it make itself the object of *jouissance*, and whose jouissance is it then? In the resuscitation service, it is above all to this question that we find ourselves confronted. Is it not necessary to preoccupy ourselves about ensuring that the child can already be an object for someone?

Too sick and unable to fabricate the mother, to trigger primary maternal concern, the baby can sometimes not even be an object for the doctors who are questioning their ability to save his life or, even worse, their ability to wish him to live, when the risk of sequelae becomes too great. If from the outset the question of the decision of stopping the trauma care arises for the team, their relationship with the child is changed.

The baby becomes a problem for the doctors that they prefer to forget. Speaking about him can trigger or rekindle new or already existing conflicts in the team, talking about him causes uneasiness and one avoids talking to him by limiting oneself to medical procedures. It is from then on impossible to suppose him a subject, impossible for the doctors to interpose themselves between the baby and his machine, impossible for them to fulfill the wishes of the baby.

The baby by nature is always questioning the other, even when he weighs 500 grams and is less than three months old! He looks for our eyes, opens his mouth when we talk to him, as if to swallow the words that are addressed to him. There is no one more talkative than a 500-gram baby so long as we take the trouble of listening to him. Like all babies, he always seeks to explore what is for him the desire of the Other.

If the parents do not address themselves to him and if the caregivers avoid him, there is no more Other which he could make himself the object of. He then identifies himself with the world that surrounds him: a pure real to which he can give no meaning. Winnicott gives us an idea of what the baby, alone in his incubator, can feel cut off from his mother whose signals, voice, warmth, smells, rhythms, noises of the body he has lost, which it can only reach in his life continuum. In this time of resuscitation, the world to which the baby identifies, is above all his machine. He merges with that absolute Other if no one comes to pick up the slack. The machine becomes part of his body. Then for ventilation to be effective, the baby oughtn't to fight against it by opposing his own respiratory movements. He becomes merged with the machine. He then can't feel himself alive; it is the machine who exists for him in a closed system. Some suffering children start to become attached to the machine's tubes, perhaps to reassure them-

selves, they seem to cling to it like a lifeline. When this is the case, we can no longer capture their gaze. They are as if fascinated by the respirator, as if they have fallen in love with the machine. It is the machine who gives the baby oxygen, feeds him without interruption, without discontinuity, and without making the baby wait. The machine supports everything, but responds to nothing. The question of setting up the drive circuit is therefore posed. In intensive care, the baby does not know lack, the cry is not turned into a call. Anyway, a ventilated baby can not cry. On the other hand, he can silently weep. But tears are not detected by the machine. No meaning can be given to them. They can not trigger any emotions. The machine makes noise, but it does not see anything, does not feel anything, does not say anything. It records numbers, makes curves, but it doesn't hear. Unlike the mother, it never gets overwhelmed. However, it is to this machine that the baby finds itself attached, literally and figuratively. (There are some children who can not stand to be de-ventilated if we do not leave next to them the noise of the machine!)

Parents are on the sidelines, doctors wonder if our society, which strives to diagnose, prevent, eradicate normality in all its forms through ultrasounds, preimplantation diagnoses, amniocentesis, do not manufacture its own disabled by these intermediaries? Doctors, too, risk divesting babies. Left in a vacuum, children exist without existing. Do they even have a status of being, or are they some machine bodies, living but devitalized? To conclude, it is by citing again Winnicott that this question will take for the teams and the parents another twist; let us not forget, he says: "the baby is a potential individual who for us, hasn’t cease to look like a little man.” Again, it is neces-

sary that we never cease doing everything we can to resuscitate this affirmation, quiet subversive in a medical department.

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