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The Attachment Imperative: Parental Experiences of Relation-making in a Danish Neonatal Intensive Care Unit

In this article, we explore how parents establish relations with extremely premature infants whose lives and futures are uncertain. Drawing on ethnographic fieldwork in a Danish Neonatal Intensive Care Unit (NICU), we engage recent discussions of the limits of conventional anthropological thinking on social relations and point to the productive aspects of practices of distance and detachment. We show that while the NICU upholds an imperative of attachment independently of the infant’s chances of survival, for parents, attachment is contingent on certain hesitations in relation to their infant. We argue that there are nuances in practices of relation-making in need of more attention (i.e., the nexus of attachment and detachment). Refraining from touching, holding, and feeding their infants during critical periods, the parents enact detachment as integral to their practices of attachment. Such “cuts” in parent–infant relations become steps on the way to securing the infant’s survival and making kin(ship). We conclude that although infants may be articulated as “maybe-lives” by staff, in the NICU as well as in Danish society, the ideal of attachment appears to leave little room for “maybe-parents.” [parental experience, infants, reproduction, attachment, detachment]
was extremely sick in his heart and lungs. During the night his blood counts turned critical. Scanning his brain, Dr. Nana had detected a grade four bleed (most severe). Talking about the high risk of serious motoric and cognitive disabilities and even of non-survival, Dr. Nana and Carl’s parents agreed to withdraw treatment. Around six o’clock in the morning Carl died. During a subsequent staff meeting, Dr. Nana reported, “The parents are in deep shock. Yesterday, they thought Carl’s situation was improving and now they feel angry and confused.” Nurse Sarah added, “The parents do not want him buried. They were ready to stop treatment right away and they want to get out of here and away from their son as fast as possible. They have had enough of us in here [De er så færdige med os her]. But we recommended them to stay at least 24 hours to sleep on it and let it sink in.” Dr. Frederic commented: “Many nonbelievers tend to regret it if they don’t get to say a proper goodbye.” Nurse Sarah said: “The parents do not want him baptized or buried, but I told them to call for a mortician anyway. They cannot escape that, legally. They are legally obliged to take care of their offspring.” Then she turned to the first author, and said; “Morticians are so good at talking to people in grief about the dead, the loss, the saying goodbye and that whole process which is so important, no matter if you are a Christian, or if you want a funeral or not.”

On this winter morning in the Danish NICU, Dr. Nana and Nurse Sarah evoked a larger cultural imperative of attachment that appears to dominate experiences of neonatal loss in Danish society. Like the staff members in this case, most staff in the NICU seem to be of the opinion that there are positive ways of letting go of a dead infant through rituals of burying and saying goodbye. Referring to Danish law, they claim, moreover, that parents are obliged to take care of their infant also in death. In other words, both by the clinic and the state, parents are encouraged to inhabit the category of parent in particular ways, and infants are established as persons worth attaching to, no matter if they are dead or alive. As we shall see, not only parents who lose a child, but also parents of living infants may enact multiple forms of avoidance, distancing, and detachment in relation to their child if the future looks closed or unclear.

In this article, we explore the ways in which parents in a Danish NICU establish and enact relations with infants sometimes categorized as “maybe-lives.” This term refers to the individualized and “wait and see” approach to infants for which Danish neonatologists are known in the international community of neonatology. This is in opposition to a more active treatment culture in neighboring countries like Sweden and Norway and in the United States (Gallagher et al. 2014; Wang et al. 2014).

First, we situate our study within existing discussions of attachment in the Danish health care system as well as in anthropology. Second, we describe the methods of the study. Third, we explore how the NICU staff articulate parent–infant relationships. We show how NICU staff uphold a strong ideal of attachment and frame every infant as a person worth relating to, although not all infants’ lives are considered worth living. Fourth, we explore how parents experience relationships to their infants and we argue that practices of detachment are integral to practices of attachment in forming the bonds of kin. Finally, we suggest that although
infants are sometimes described as maybe-lives by staff, there appears to be little room for “maybe-parents” in the NICU.

Addressing Attachment

By Danish law, parents who experience stillbirth or infant death within 32 weeks after birth have the right to 14 weeks of paid leave for the mother and two weeks for the father (https://www.retsinformation.dk).1 Also by law, men and women who experience infant death are obliged to facilitate the burial of their offspring (https://www.retsinformation.dk).2 The Danish state thereby emphasizes the value of very young human lives, establishing the mother and father unquestionably of the child as parents, morally and legally. These laws constitute important underpinnings for the way attachment is addressed in the Danish NICU. In this setting, family-centered care has been part of policy and practice for more than 30 years, highly influenced by the United States (Cooper et al. 2007; Greisen 2008).

“Care for parents is about supporting the development of family functions,” the NICU webpage states, and in neonatal nursing science bonding is seen as a precondition for infant growth and development as well as crucial to the development of parenting skills (Fegran and Fagermoen 2008; Fonagy et al. 1991). In the Danish NICU, staff invite parents to stay in the clinic 24-7 and tutor them as to how to participate in the care of their infant. In 2014, a guideline recommending the kangaroo-method (skin-to-skin contact between parent and child) was implemented, stressing the importance of physical attachment (Pallás-Alonso et al. 2012). In 2015, the Danish NICU was successfully certified in the American NIDCAP care program (Newborn Individualized Developmental Care and Assessment Program), a program that aims to support the well-being of the infant in the NICU by tutoring parents and staff in how to read the needs and emotions of individual infants who have no verbal language (Kleberg et al. 2000). These NICU policies and guidelines draw a picture of a clinic that parallels successful treatment of premature infants with successful establishment of parent–child relationships.

Not only in the clinic but also within anthropology, social relations have been and still are defined as the center of social life. Anthropologizing attachment (Stafford 2003, 3), many scholars have addressed issues of connections, ties, and bonds within the analytical framework of kinship and relatedness (Carsten 2000; Radcliffe-Brown 1940; Schneider 1980 [1968]). Studying pregnancy, birth, childhood, parenthood, loss, and infant death, anthropologists have documented cross-cultural variations in social relation-making around the world (see, e.g., Turner 1964; Van Gennep 1960 [1908]).

In the field of reproductive anthropology, prominent feminist voices have advocated “breaking the silence” and recognizing women’s experiences of attachment around pregnancy termination and loss in the United States (James 2000; Layne 2003; Rapp 1999) and in Vietnam (Gammeltoft 2014). Others have said that attachment theory is ethnocentric and insensitive to cultural variation (Quinn and Mageo 2013). A well-known voice in the anthropological attachment literature is Nancy Scheper-Hughes’s work on infant death and mother love in Brazil (1992). Writing against psychological theories of mother–child attachment as universal scripts
(Bowlby 1953), Scheper-Hughes asserts that human emotions are culturally constructed and shaped by socioeconomic circumstances (1992, 400ff). In the case of el Alto in Brazil, political violence, extreme economic deprivation and high infant mortality shape maternal practice and thinking, sometimes leading to emotional indifference or “delayed attachment” (1992, 340). Scheper-Hughes holds the strong view that attachment equals maternal love whereas detachment equals neglect, and that it is global inequalities that produce practices of detachment among mothers and their infants in el Alto.

What happens to the analytical concept of attachment if we change the ethno-graphic scene from maternal indifference with newborns in the Brazilian slum to parental hesitations of attachment around premature infants in Denmark, where poverty, starvation, and political violence are not part of the larger constellations of parent–child relation-making? Conducting fieldwork in the Danish NICU, we soon realized that there is no such thing as a simple relationship between levels of attachment and socioeconomic hardship. Rather, we noticed how forms of hesitant attachment in the clinic disturb normative distinctions between detachment as a social harm and attachment as a social good (Candea et al. 2015). Taking detachment as our analytical starting point, we are inspired by recent work on detachment, separation, otherness, and disconnections (Candea 2010; Candea et al. 2015; Stafford 2003; Stasch 2009). These scholars challenge a solid orientation in the anthropology of relations that assumes that mutual identification, unity-based communities, and close relationships based on sharing intimate space are the main pillars of relation-making (see Tönnies on Gemeinschaft 1957 [1887] and Durkheim on social cohesion, 1964 [1887]).

Contrary to these engagement-romanticists (Candea et al. 2015, 3–6), Matei Candea argues that detachment should not be seen as the opposite of involvement, nor as necessarily a form of “standing back,” “retreating,” or “distancing” from social interaction (Candea 2010, 250). Rather, in his multi-species ethnography on the relationship between scientists and meerkats in the Kalahari Desert (2010), Candea demonstrates that forms of engagement and detachment make one another possible and exist concurrently (Candea 2010, 247). The scientists in the Kalahari Desert, Candea shows, try to build a relationship with the meerkats through refraining from intervening in their natural habituation. Meanwhile, the meerkats refrain from running away from the humans by ignoring their presence, which in many other situations they would consider a threat.

With this case, Candea argues that acts of detachment are part of acts of engagement and produce forms of (interspecies) social interaction (Candea 2010, 249). Long before Candea’s ethnography from the Kalahari Desert, Radcliffe-Brown addressed joking and avoidance in social relationships (1940, 202) and described “relations in which there is both attachment, or conjunction, and separation, or disjunction” (1940, 203). However, while Radcliffe-Brown recognized the coexistence of attachment and separation in a relation, this was specifically restricted to certain kin relations (e.g., grandparents and mother’s brother and mother-in-law). Taking our cues from Radcliffe-Brown and Candea’s work, in this article we dissolve conventional moral distinctions embedded in the concept of “social relation,” approaching practices of attachment and detachment as embedded in one another; as social cooperators in the work of establishing relations.
To view a social relation as co-composed of both attachment and detachment is also central to Rupert Stasch’s ethnography of the Korowai people in Indonesia (2009). In his book, Stasch exemplifies how qualities of otherness are at the heart of Korowai kinship. Avoiding sharing plates and keeping physical distance in certain conversations are some of the ways in which Korowai people recognize and maintain social ties (2009, ch. 2). However, avoidance, he says, is not anti-relational, but a “form of intense reciprocal engagement” (p. 87). Stasch unfolds his argument even further by emphasizing the huge daily work that it takes adults to turn newborns—associated with nonhumans, monsters, and demons—into persons to whom they can attach and begin to associate with companionship, care, and hope (pp. 142–54). Following Stasch’s point, we discuss how abstaining from touching and holding an infant during critical periods, for example, can be viewed as ways in which parent–child relations are recognized and maintained, and how acts of avoidance give way to intense, intimate, but also unsettling and uneasy engagements in the NICU.

Although the Danish case speaks against Scheper-Hughes’s view that detachment equals indifference or even neglect and is an effect of poverty and political oppression, we do find resonance between mothers in el Alto and parents in the Danish NICU, as Scheper-Hughes’s work convincingly demonstrates that parents’ faith—or lack of it—in a shared future with their infant shapes their emotions (Scheper-Hughes 1992). Temporal imaginaries of the infant’s future also appear to play a central role in the parental practices we observed in the NICU. Our empirical material documents the ambiguities, conflicts, and clashes at stake when people try to make kin(ship) out of maybe-lives and prompts us to discuss how practices of attachment and detachment are embedded in one another.

The Study

This article is part of a larger research project, in which we ask how lives worth living are practiced and experienced in the Danish welfare state in the 21st century. The fieldwork on which this article draws is conducted in Denmark’s largest and most specialized NICU, which covers a broad field of neonatology from infants born between weeks 23 and 36 (NICU) to critically ill babies up to the age of 24 months (PICU: pediatric intensive care unit). In this article, we concentrate solely on the extremely premature infants born in gestational weeks 23–27, more than three months before term. From 2013 to 2015, the first author conducted six months of ethnographic fieldwork among parents, staff, and infants in a Danish NICU; in 2010, the third author conducted one month of fieldwork in the same NICU.

Between December 2013 and July 2014, the first author followed 30 extremely premature infants’ trajectories and conducted hours of observations and informal conversations with parents and staff exploring how they negotiated the value of infants’ future lives in making life-and-death decisions and how they reconstructed meaning and sense of control in the face of loss and uncertainty. Staying with parents and nurses around incubators and following doctors on day and night shifts, the first author participated in daily care, medical rounds, staff conferences,
and consultations between parents and staff, attending in particular to the ways in which the infants were articulated as moral persons, ascribed agency. Ten of these 30 infants died within their first month after birth.

Although the first author has not done follow-up interviews with parents whose infants died, she did, however, talk to the couples during admission and participated in four follow-up “mors-conversations.” Together, the first and the third author conducted interviews with 18 staff members and the first author interviewed 10 parents (in their homes after discharge) about their experiences of becoming parents in the NICU. All cases and names of infants, parents, and staff are altered to secure the participants’ anonymity. The analysis in this article is the result of continuous conversations between the three authors. The second author’s ethnographic work on reproductive decisions in Vietnam and the third author’s research on reproductive technologies and human–animal relations in biomedical research in Denmark serve as comparative lenses through which our study of life’s worth in the NICU in the Danish welfare state is continuously tested and contested.

Premature infants’ bodies and brains are very immature, and compared to a woman’s uterus, the NICU constitutes a primitive environment. Yet, at the moment of birth the infant is no longer primarily dependent on the mother’s nurture and care. Rather, during the first days, weeks, or months of life, the infant’s ability to breathe, eat, or digest depends entirely on machinery, medication, and specialized intensive care staff. When a risk of premature birth is identified, neonatologists inform the parents (in perinatal consultations) about the prognostics for infants born between weeks 23 and 27 of gestation. Parents are told that these infants have a 60% chance of survival and 30–50% of surviving infants risk having a disability. The disabilities presented to parents vary from severe brain damage (cerebral palsy), along with risks of compromised lung capacity, life-threatening gut infections to some degree of learning, sight, and hearing disability. These extremely premature infants’ lives are marginal and uncertain.

Accessing the NICU as anthropologists involved subtle negotiations of the appropriate levels of engagement and detachment (Candea 2010, 247). The head of the clinic gave us free access in and out of the NICU, yet every day in the clinic felt like a renegotiation of how and when to approach parents and infants in critical situations of life and death, as expressed in this field note from the first author’s first day in the NICU:

Marcus is one week old, born in week 27, weighing 700 kilo grams. As I lift the blanket covering Marcus’s incubator I realize that he looks right back at me. His eyes are blank and his gaze unfocused. He is so tiny. I expected him to be asleep. His mother is asleep in the bed next to him and I come to feel that I am “stealing” away an important moment from her. Marcus looks scared, and I think about all the things Marcus has gone through today; brain-scan, blood samples and washing. I feel bad to intrude on his private moment, yet, I cannot keep myself from looking into his eyes and I wonder whether he will make it and how. Half an hour ago I overheard the doctor tell his mother that they detected a cyst on his brain. They believe it is
nothing dangerous, but they have to observe how it develops. I can’t help linking his unfocused gaze to a possible brain damage, even though I am perfectly aware that this may just be because his eyes are not fully developed.

While this field note may capture a moral ambiguity within the anthropologist, more importantly it resonates with an ambivalent experience expressed by many parents during interviews: a desire to protect and connect with the infant, and yet a hesitation to engage, linked to the infant’s unknown future prospects and what some parents described as the infant’s alien or animal-like appearance.

Creating Meaningful Lives by Attachment

“We articulate that even a short little life has value, both for the child and for others,” the former head of the clinic told us back in 2009. Side by side with the articulation of every infant as a life with value for others, NICU staff refer to these extremely premature infants as maybe-lives [måske-liv] (Svendsen 2015), expressing a medically uncertain viability. During fieldwork in 2014, the head of the clinic likewise told us, “In this NICU we allow ourselves to say ‘A’ without necessarily saying ‘B.’” This means that even though the doctors may initiate active treatment at the moment of birth, they may still decide to withdraw treatment later on, if the infant does not respond well to treatment.

While practicing this wait and see approach to infant futures, staff hold a strong ideal of parental attachment and encourage parents to hold on, no matter the infant’s expected chances of survival. Dr. Nana expresses it this way:

For some parents it takes time to attach emotionally, and we try to help them articulate this by saying: “It’s quite natural.” Some parents are really scared to get too attached, because they know they might lose the baby and then we will respond differently by telling them: “You have to attach to your baby, you never know.”

In the everyday care, nurses tutor parents in how to hold, feed, and wash their infants; guiding their hands within the incubator. Following the NIDCAP-program, the nurses teach parents to read the infant’s “language” of (dis)comfort by checking the monitor measuring blood pressure and oxygen level. Marking micro-signs of progress in the infant’s trajectory, the nurses hang up Disney-decorated first-month-flags and encourage parents to celebrate the infant’s weight gains with kilo-cakes. Infant rooms in the NICU consist of 100 ft² crammed with things and people: two incubators, two parent-beds, two ventilators, and documentation stations with PCs for nurses, a kitchenette, a parent chair, and a closet.

Most often, two infants and their parents spend month after month in such rooms and most often the incubators are surrounded by teddy bears, drawings, and sometimes poems brought into the clinic by parents and/or siblings. Sitting on the bed, parents make scrapbooks, read, knit, work, Facebook, and whisper with infants, other parents, and staff. Therefore, it is starkly obvious when a parent bed is empty day after day and when an incubator stays undecorated. Even though the NICU staff often encourage parents to “go home and get some sleep” or “have some
couple-time,” they have a clear opinion about parental presence. This is illustrated by the case of Lin’s mother, a woman in her 30s. Coming from an Asian country, Lin’s mother had spent almost two years in Denmark when she gave birth to her daughter:

Nurse Morten and Dr. Nana prepare for the morning round on Lin (born in week 25, now three weeks old) and agree that she is doing very well. Morten says, “The mother is absent.” “Why is she absent?” Dr. Nana asks. “She’s been admitted to the maternity unit and the staff up there are discussing whether it’s because this is the normal practice where she comes from [Asia],” Morten says. “Well, she has to come down here,” Dr. Nana says. The first author asks: “So you have a clear opinion that the parents ought to be present in this department? “Yes, we interfere!” she replies, “We tutor the parents and encourage them to come here, also to get the breast feeding kick-started. ( . . . ) Sometimes we even make a come-and-go schedule.”

Nurse Morten leaves to find the mother and invites me to join him. We find her in the hallway of the maternity unit. Morten addresses her, “Why are you not with your baby?” “I was there yesterday,” she replies. “Yes, for an hour,” he comments, “but there is a bed where you can sleep.” “I’m planning to go home now, because I sleep terribly at night, I wake up soaked in sweat. I have to go home until the sweating stops before I can be with my baby,” Lin’s mother says. “For how long are you planning on going home?” Morten asks. “Maybe a week,” she replies. Nurse Morten is obviously shocked: “You have to be with your baby! It’s important that you’re there for your child, that you touch her, and give her attention, and she needs you to touch her and be near her; not least to get your milk-production started. “But the father will be here,” the mother says, and sounds surprised at Morten’s reaction. “Yes, that’s fine, you can both be there. There’s room for you. You’ll get a bed next to your child. But you are the mother and ( . . . ) you have to be with your baby!” We say good-bye and Lin’s mother thanks Morten, shaking his hand.

Although absence of parents is rare and the directive tone of staff is exceptional in the Danish NICU, this episode illustrates nevertheless a general expectation among NICU staff that parents ought to build a close intimate bond with their infants. Such expectations are far from universal; for example, they contrast the situation Bo K. Seo observes in a Thai NICU where parental presence is rare but largely accepted and where staff take responsibility for the care and protection of infants (Seo 2016, 4–5). To Lin’s mother, leaving the hospital was a necessary step before she could be with her baby. Reminding Lin’s mother, that “there is room for you,” Nurse Morten underlines how the ideal of attachment and sharing social and intimate space is supported by the physical organization of infant rooms (a bed for parents placed next to the infant) and by the policies of family-centered care presented above. Morten’s encouragement of Lin’s mother’s presence reflects conceptions of good parenting for newborns in Denmark, which rests on theories of skin-to-skin contact and maternal breastfeeding as effective ways of building parent-child relationships and enhancing the infant’s chances of survival.
As strong as the clinicians’ opinions on parent–child attachment appear, equally strong are their omnipresent professional and personal doubts about whether they are making the right decisions on matters of life and death on behalf of infants and (together with) families. We learned that the doctors consider doubt an important “skill” that they must use to not become insensitive or inflexible in end-of-life decision-making. Doubt, we might say, works as an ethical guardian. This doubt is also described by Jessica Mesman in her work on medical uncertainty as a constant companion in neonatology (2008). However, the Danish doctors’ doubts, we learned, are not only linked to medical uncertainties, but also to relational uncertainties. When an infant is at the margins of life and a decision about whether to continue or withdraw treatment must be made, questions like, “Do the parents want everything done?” “Do the parents have children already?” “Is this the parents’ last chance of having a child?” enter the staff meetings, together with discussions of biomedical parameters, and laboratory and radiographic monitoring. We might say that parental commitment and engagement become points of orientation when clinicians seek answers to the difficult questions of how far to go in trying to save a child, and to what kind of life. In short, the strong attachment imperative among staff, we suggest, appears closely linked to the clinicians’ ongoing work of making the prolongment of precarious life meaningful.

Detachment as Integral to Relation-making
Imagine a visitor arrives unannounced, at an inconvenient time, stays in the doorway, and “threatens” to leave any minute. When infants are born extremely premature, the process of anticipating a new family member’s arrival is upset. In the following, we analyze how parents experience establishing relations with infants in situations they describe as marked by temporariness and uncertainty by using the analogy of “guest–host” relations. We begin with the words of Peter’s mother:

I remember it was the day after his birth that we saw Peter [born in week 24] for the first time. As we entered the room the doctor was examining him and Peter was screaming and wriggling. Then the doctor said: “Wow, he is very strong and has a temper! I’m glad I’m not the one to handle him when he turns 18 and comes home from a night in town!” His words were such a relief, because at that time we were depressed, just standing there by that incubator thinking, “What the hell is this?” I cried. I was shocked that he was so tiny. You know, they’re not cute, in any way. They look all scrawny. There is just nothing lovely about that. Of course it is your child, but, that wasn’t exactly what we had in mind. ( . . . ) The staff said, “Well, he’s such a wonder child (stjernebarn),” because he didn’t need a respirator to breathe. It was nice to know that he was doing really well. It was also wonderful that we could have him lying with us for hours every day. The staff told us how important and healing it is for the infant to lie there, but they also prepared us that typically these infants have a so-called honeymoon period during the first week of their lives, and then it can turn really bad. And that was exactly
what happened to Peter; after a week he was attached to the respirator and then everything just went downhill. We almost lost him three times during the first two months. As he lay there with a huge tube, and all that equipment, tape and stuff, we were suddenly not able to touch him. That was terrible. Getting him out of the respirator to lie with us was such a huge project with all those tubes which—God forbid—must not be unplugged. Then you also have to find other ways of being there for him, reading, singing for him.

With the words “we almost lost him three times during the first two months,” Peter’s mother brings to mind the “roller coaster” metaphor that Linda Layne (1996) suggests characterizes the peculiar experience of time in NICUs where conventional conceptions of time as linear are constantly challenged by the unpredictable nature of premature infants’ trajectories (p. 629). In addition, when Peter almost died three times in two months, his parents experienced moving back and forth between greeting him welcome and good-bye. We find that the visitor analogy adds an important analytical edge to understanding the parental experience of continuously near-loss of infants; it brings to the fore how parents enact a form of hesitant hospitality and insecure attachment. Each time Peter’s parents nearly lost him, new worries about his future state of being and quality of life piled up and created further uncertainty about the nature of their future parent–child relation.

As in the interview with Peter’s mother above, the images of a tiny, scrawny, and non-cute being came up repeatedly in interviews with parents and indicate the infant’s qualities of otherness (Stasch 2009) and the parental “contingency of estrangement” implied in caring for these infants (Seo 2016, 2). On day one, the doctor instilled personal qualities of strength and temper in Peter and pictured an open and “normal” future for him (“when he turns 18 and comes home from a night in town”). While this encouraging remark removes Peter from the category of “temporary household visitor” (Scheper-Hughes 1992, 340) into the category of a life-long kinship and care-commitment, the staff simultaneously introduce the potential relational disjunction when they prepare the parents for the ups and downs awaiting them. Radcliffe-Brown’s work on relations expressed mainly in terms of prohibitions (1940, 2017) comes to mind when Peter’s mother mentions how the restrictive setup around her boy prompts her “to find other ways of being there” for him. However, whereas Radcliffe-Brown argues that avoidance and prohibitions serve a function to uphold social order (alliance) between somewhat fragile or potentially problematic relations, we argue that the nexus of attachment and detachment are inherent in any social relation.

In the Danish NICU, we found that people such as Peter’s parents have to navigate between two main temporal imaginaries of either leaving the hospital with a baby they can take home, or potentially losing their child. Between these two seems to be an all-encompassing “here and now” in the clinic, where infants are still medically in the category of maybe-life, but parents are expected to attach “as if” the infant would definitely survive. The parents we met characterized their being in this temporal limbo as “being in a prison,” “in a war-zone,” or in a “state of exception,” similar to what Victor Turner has described as an experience of
liminality (Turner 1964); thereby signaling that normal time was suspended. These temporal imaginaries along with the infant’s alienating appearance and the clinical environment shape parental practice and thinking (see Scheper-Hughes 1992). Lisa’s mother describes it this way:

At the beginning I barely dared to hope for anything. I was afraid she [Lisa, born in week 27] would die, and that stopped me from making any attempts of motherly attachment. When I saw her the first time, lying in that “nesting box” [fuglekasse], as I call it, with all those patches in her head, I could hardly see her face and I thought: What is that? That can’t be a child, really.” So probably a month and a half passed by before I became attached to her.” [In Danish, der gik halvanden måned før jeg knyttede mig til hende]. I did all the things they told me to, but it might as well have been someone else’s child they asked me to take care of. And I could hardly hold her . . . well, to hold her I had to first ask a lot of people to help me with all kinds of stuff, to initially take out all the tubes. . . . And putting my hands into the incubator, a nurse would ask me: “Did you sterilize your hands?”

Like Lisa’s mother, many parents describe how they hesitate to attach to their infant as long as the future is still uncertain. Furthermore, many parents experience that the particular physical and material setting of incubators, tubes, patches and staff moving in and out shapes the parent–infant relation-making. In everyday life in the clinic, the uncertain future is confirmed by regular resurrection attempts (frequent apnea in infants), intubations, ex-tubations, routine brain scans, and X-rays. While these diagnostic tools assist the doctors in estimating the infants’ risks of future disabilities, staff and parents seem to agree on the importance of keeping up parental hope (Hall 2005), regardless of the imagined future. Indeed, hope is considered a facilitator of attachment in the Danish NICU. However, the parents also experience fluctuations in and out of hoping and long periods of waiting and seeing, of attaching to the infant as if it will survive, and such times come to resemble moments of suspended hope or hope put on probation (Reed 2011).

As they move in and out of hoping, the parents also move in and out of feeling like a parent. In the following, we explore how NICU parents draw on contrasting possibilities in relationships as they try to carve out a way of parenting that fits the uncertainty they face (Stasch, 2009, 16).

The daily routines of child care in the NICU constitute pumping out milk on a machine, fetching milk from the milk kitchen, sleeping only briefly, intermittently—or not sleeping at all—next to an incubator, attending the oxygen alarm, the infant’s apnea, anticipating tiny steps of progress, detecting concern in the doctor’s tone of voice. While these micro-routines of care may resemble those around mature babies, there are small deviations: Milk leaves the mother, passes the pump, enters kitchen (or donor bank), mother’s or other mother’s milk enters the infant through a syringe, parental holding is mediated by tubes, patches, soap, and nurses reminding parents to sterilize their hands, and so on. Parents need to navigate the gap between expectations of authentic ways of inhabiting the category of
parent and actual possibilities of parenting in the NICU as illustrated in this field note:

Sam was born in week 24, weighing 380 grams. Within his first weeks, he underwent an operation in his guts due to a life threatening infection (NEC: Necrotizing Enterocolitis), had a piece of his colon removed and a (temporary) colostomy inserted. Standing by the incubator, Sam’s mother, Sally changes his colostomy and she instructs the first author to feed him by holding the syringe with milk close to the comforter covering Sam, while holding his hand. Sally explains: “I was so unhappy about not being able to be the mom I had pictured, and I have compensated by taking control of the colostomy, medication, and everything around him.”

The feeling of not being real or authentic as a mother is well described in anthropological studies of IVF-technologies (see Tjørnhøj-Thomsen 2005; Weston 1995). To become the mother she had pictured, Sally wanted to be able to take part in the culturally valued task of caring for her son; in this case, she had to take on the nurse’s specialized task of handling his colostomy. The practice of changing a colostomy is not equivalent to changing a diaper. Wheras the parental expectation of temporary dependency as a way to permanent independency frames the conventional diaper-changing of infants; changing Sam’s colostomy did not unequivocally carry the promise of future independence. Sally established herself as different from the wished-for-mom as she takes on the role of his nurse, she says. To Sally, we might say that it is exactly through the strict routine procedures (techniques) described above that she carved out a different space of possibility for establishing mother–child relation. Sally enacted what we term attachment through detachment as she struggles to become the mother she imagined herself to be. In an interview with Sam’s parents in their home after discharge, Sally stressed that while she readily accepted the staff’s invitation to participate, her husband refused to do so and did not spend much time in the NICU. Sam’s father explains:

Well, one was afraid he would break into pieces. ( . . . ) We were told that the first two weeks are the most critical. ( . . . ) I had no problem looking at him, but to touch him and to take part in all those things. This is the powerlessness you feel; what the hell can I do? I can’t do anything. Even to change his diaper was for me to get too close to him. To feed him, aaah, that started as I ran from the maternal unit to the NICU with the first milk coming out of Sally’s breast. It was crazy, just enough milk to lie on a cotton swap . . . and to stick that into Sam’s mouth was surreal . . . and it was not until later that I realized that I actually gave him something in that moment. I think that created a distance between him and me.

I have been there every day . . . but as a man you feel a little bit on the side (på sidelinjen). ( . . . ) Well of course it is your baby and all that . . . but being in the NICU, which is very women-focused . . . I felt like a fly on the wall. But I know this was because I didn’t say: “Now, I wanna be part of it.” As a dad you feel like, what difference, does it make whether I am here or not? I
mean, it’s incredibly hard to accept that all the care and love you urge to give, is through the two holes in the damn incubator—after you’ve washed and disinfected your hands several times to avoid the germs and infections. Going through this entire procedure just to get to touch your child, that is completely surreal. It is as if you have to fight a war before to get to hold your child, you know?

These lines evoke so clearly the ambivalent experience of attachment and detachment that many parents articulated. The experience of distance comes to the fore in expressions such as feeling like “a fly on the wall,” being “on the side.” Refusing to take part in the care work around Sam, feeling that changing his diaper was “getting too close,” feeling uncomfortable in the beginning about touching and feeding Sam, not spending too much time in the NICU; such acts could be seen as micro-acts of detachment. Describing the NICU as women-focused, we might understand Sam’s father’s practices of hesitant attachment as a gendered response to the experience of liminality: He simply feels pushed into the background of the care work.

While gender roles probably are a central issue here, we propose there is more to it. Using the strong images “to fight a war to get to hold him” and “to give love through the holes of the incubator,” Sam’s father uses metaphors of fences or borders that have to be transgressed in order to make a relation. Physical hardship, endurance, and distance are at the core of these images. However, a closer consideration of his “looking back” at the feeding situation the day his son was born, reveals that Sam’s father’s emotional ambivalence is not a sign of indifference or neglect, but a way of being there (“I have been there every day”), approaching his son through various forms of avoidance.

Rupert Stasch asserts that avoidance is also a relational act, which can be a way people work to maintain certain relations (Stasch 2009; see also Radcliffe-Brown 1940). Like researchers described by Candea who practice a polite detachment in relation to the meercats anticipating the right time and way to approach them and interfere in their natural habituation, Sam’s father’s experience of approaching his son seems to be one of “guarded watchful waiting” (Scheper-Hughes 1992, 410); he is simultaneously near and distant in relation to his son. Giving love through holes in an incubator, was to all the parents we met, considered emotionally confusing. Most parents interpreted their own acts of distancing or avoiding as social “harms” (Candea et al. 2015) and obstacles on their way to becoming “real” parents. However, in line with recent science and technology scholars’ attempt to establish symmetry between care and technology, we resist reading Sam’s case as a clash between cold technology and warm parental care (Pols and Moser 2009). Rather, we suggest, parental acts of avoidance or hesitation in relation to their infants are integral to producing engagements.

In Stasch’s work, the Korowai landowners avoid traveling through taboo sites on their lands out of fear that the land resources will be damaged or attacked (Stasch 2009, 32). In the NICU, sterilizing your hands and deep-freezing teddy bears before putting them in the incubator are acts that have a transformative potential: Not doing these things holds the danger of contamination. There even has to be a policy of “minimal touch,” a recommendation that parents and staff refrain from touching or caressing unstable neonates; yet all these distancing measures,
paradoxically, offer the potential for the parents to connect and relate to their infant (Landzelius 2003).

Even though the parents made explicit that abstaining from certain care tasks gave them the feeling that their parenting was put on hold, acts of abstaining from interventions (feeding, holding, etc.) were gradually integrated into their perception of good parental care in the NICU. During sterile procedures, parents were recommended to stay outside the infant’s room, not only to avoid infection risks but also to spare the parents from the emotional hardship and constant fear of losing the infant, which may increase during such procedures. We suggest such acts of separation pave the way for “livable” and ongoing parent–child engagement and that forms of separation, avoidance, and emotional reservation are integral to relation-making.

In Stafford’s edited volume (2003), he explicitly argues that the work of maintaining, developing, and reaffirming social ties is a continuous work of overcoming various distances and dealing with leave-taking (pp. 3ff). While we do not see separation as something to be overcome, we consider the physical and emotional distances Peter’s mother and Sam’s father describe as integral to their relationship with their sons. With the opening case of Carl, we wanted to illustrate how practices of hesitant attachment, leave-taking, and withdrawal sometimes collided with NICU (and state) expectations of attachment to infants, dead or alive. When the first author met Carl’s parents again one month after his death, they had buried him and the mother was happy to have a place to go and visit him. In Carl’s case, the parents’ desire to leave the clinic immediately after his death could be seen as a way in which they asked for room for ambivalence in attachment; involving immediate distancing and avoidance as a way to overcome the shock of losing a child (born in week 31, nobody talks about maybe-life) and as an act of attachment through detachment. In other cases, parents brought their dead infant home and let older siblings kiss the infant goodbye. These practices of engagement suggest that the process of creating kinship can even cross the realm of life and death and can be established through acts of separation, grief, and loss.

We began this section with an image of a stranger coming to visit, staying in the doorway, and threatening to leave any minute. The analogy between marginal newborns and temporary (household) visitors/guests is not new (Scheper-Hughes 1992; Seo 2016), but it serves well to illustrate what is at stake for parents and staff as they host maybe-lives and provide hospitality. According to Stasch, host–guest interactions serve as examples of human processes of establishing and maintaining relationships, showing how these interactions always entail risk and exposure. Both guest and host may lose or gain something, materially or socially (Stasch 2009, 105–39). In Denmark, having a child is usually considered the most permanent of all human engagements. However, in engaging with marginal infants, parents and staff face the potential loss of (family) life and its associated emotional pain. For some parents, the fear of death lasted only for a couple of hours, while for others it lasted for days, weeks, or months after birth. It is within this period of anticipation (when the infant threatens to take leave any minute) that we see parents practice multiple micro-practices of detachment as embedded in the relation-work of parents. These practices of detachment are neither acts of neglect nor indifference (Scheper-Hughes 1992); rather, they work as social cooperators in the process of making kin(ship) with maybe-lives.
Concluding Remarks: There Is No Such Thing as a Maybe-parent

By Danish law and in the Danish NICU, even the shortest and smallest life is articulated and enacted as a morally valuable person worth relating to and worth attaching to, yet not all lives are considered worth saving or worth living. This puts parents in a position where they must navigate opposing future imaginaries (leaving the hospital with or without a baby) and confront cultural imperatives of attachment.

The staff and the state hold a strong imperative of attachment, which seems to work independently of the imagined future of the infant. To parents, it seems, the articulation of the infant’s life as having intrinsic value contradicts the practices of assessing life and its worth in the field of neonatology (“wait and see”). For the parents, attachment is contingent on certain hesitations and tentative hope; hard to separate from the infant’s imagined future. Thus, we argue that there are nuances in practices of relation-making in need of more attention. Refraining from touching, holding, and feeding their infants during critical periods, the parents enact detachment as integral to their practices of attachment.

To conclude, we suggest that there is little room for maybe-parents in the NICU. Unlike the medical doctors, the parents are not in a position to “say ‘A’ without saying ‘B’” in relation to their infant. However, in our attempt to anthropologize detachment, we have turned our analytical lens on detachment away from a social problem, and toward detachment as a social (co)operator. We have shown that when parents unwillingly undergo the “emotional education” of becoming NICU parents, they navigate the broad continuum of forms of attachment and detachment. Moreover, we have argued that the strong cultural imperative of attachment overshadows other basic human experiences of attachment that are contingent on uncertain and hesitant attachment, yet integral to relation-making. The ideal of attachment, we propose, becomes a way parents, staff, and state mediate and deal with doubts and uncertainties. Yet, perhaps the Danish NICU and the Danish state could make more room for detachment—welcoming maybe-parents—when receiving maybe-lives who arrive earlier than expected.8,9

Notes

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1. “From the law on subsidies in relation to sickness or birth, § 13, stk. 7, follows, that if the child is still born, the mother has a right to 14 weeks of subsidies after the child’s death. Moreover it follows from this law, that the father has a right to 14 days of subsidies in the case of still birth. The law also applies to infants born after week 22” (our translation).

2. Parents of stillborn babies have a right and duty to bury the child according to the law number 346 of June 26, 1975 on funeral and cremation (our translation).


4. The introductory case of Carl is an exception to this. He was born in week 31, and his death represents an exception not only in our study, but indeed in the general statistics in the NICU. It is very rare that infants at this high gestational age die.

5. The parents’ ages ranged from 16 to 45, with various socioeconomic backgrounds: engineers, students, unemployed, home-helpers, architects, and many others. Four of the parents were not Danish citizens, but were in Denmark working, studying, or applying for Danish citizenship.

6. Perinatal consultation: preparing parents to give birth prematurely. Status-conversations: when infant’s state is critical. Mors consultations: one-on-one consultation between parents, nurse, and doctor one month after a child has died.

7. Our empirical findings unsettle not only a larger cultural ethos of attachment, but also a growing field of anthropology of hope (see Crapanzano 2003; Mattingly 2010; Miyazaki 2004; Reed 2011). However, we suggest that the strong imperative of attachment and keeping up hope overshadows another human existential condition, namely hopelessness. For future research in the field of neonatology, we suggest that we take the issue of hopelessness seriously.

8. Over 100 authors.

9. Over 100 authors.

References Cited


