Pregnancies and births risking alexithymia?

by Paola Manfredi*

Introduction

Many studies have been carried out since the second half of the 1940s when Ruesch (1948), MacLean (1949) and later Marty, de M'Uzan and David in 1963, working separately, drew attention to some modalities of psychic functioning that can be considered the precursors of the construct of alexithymia, as it was outlined in 1970 by Nemiah and Sifneos. In particular, compared to Nemiah and Sifneos's original concept, the current way of seeing alexithymia has changed: it is no longer seen as a dichotomic characteristic of the "all or nothing" kind, but as a feature that can be present with varying intensity in different subjects. It is also thought that alexithymia can affect circumscribed "mental areas" in a person's functioning, and therefore be present only for certain affects or contexts and situations (Taylor *et al.*, 1997; 2000). It has also been revealed that alexithymia goes with a certain interpersonal style, characterized by social conformity, conflict avoidance, and by bloodless, cold or distancing, superficial relationships. These characteristics then lead to alexithymic patients being classified according to a pattern of avoiding attachment (*avoidant-dismissing*) (Taylor, 2000; Verhaeghe, 2004).
Although there are no recent epidemiological studies (even since the Tas 20 validation study on the Italian population made by Bressi et al., 1996, over ten years have passed), the growing volume of studies witnesses on the one hand an interest rooted in clinical work and on the other an ever more widespread psychic functioning marked by the inability to express and elaborate affects. It has also been pointed out that the professional figures dealing with people's health and illness, who should have heightened awareness of the affects, are less capable of reading their own and others' emotions: it would in fact seem that training in Medicine selects and incentivates alexithymic functioning (Dabrassi & Manfredi 2006; Hoffmann, Formica & Di Maria, 2007).
With these premises, one wonders about the functioning of the divisions of obstetrics and specifically about the first experiences of mother and infant and about how the psychosomatic pathologies that may accompany pregnancy can be managed, in the awareness that these issues leave significant traces in our life and help to create the predisposition towards health or illness.

Affects and obstetrics: the "institutional" dimension

One respected interpretation (Guerra, 1992) holds that medical knowledge and practice have close links with three different, primitive sources of anxiety related to the secrets of life and death, the breaking of the taboo forbidding access to the other person's body and the encounter with illness and death (Guerra, 1992). While this hypothesis may be true in general, it needs to be said that for some specializations and some hospital divisions, these sources of anxiety take on a clear significance: it is reasonable to see obstetrics among these. This is where the questions of life are found, from the desire for pregnancy to the meticulous formation of a new being, through to the delivery-birth. Here death has its place, searched for or suffered: one finds it in its cruellest expressions, the death of a mother and the death of a newborn infant. There are spaces also for illness – in the wide spectrum going from those with a short happy prognosis to the fatal ones – for disabilities and for anomalies – whether they are slight or incompatible with survival. Lastly, there is the constant violation of the body of others, with a gaze that probes the internal regions and explores the most intimate recesses. And yet, here too, medicine proposes control over intense affects and profound anguish, through the use of regressive defence mechanisms that stop such affects from being thought about and elaborated.

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The dramatic force of these issues does not lie only in the real experiences in which they can be expressed; it is never simply the specific case of a patient, it is never merely a clinical story, but they are invested with pathos due to their link with the profound affective dimension of each of us. It is the terrible phantasms that dwell deep within us that explain the adoption, at an "institutional"[1] level, of defence mechanisms (denial, split, negation, isolation of the affect) that keep the staff-member from encountering stress and anxiety. The disappearance or non visibility of such affects and the compartmentalizing of reality are clear indicators of the effectiveness of this defence system. In fact, although most of the work in the obstetrics field concerns pathology, both in direct terms – the obstetrician intervenes only in pathological deliveries – and indirect terms, in the practices designed to ensure that pregnancies and deliveries do not present anomalous or risky conditions – paradoxically it is almost exclusively the positive dimensions and the reassuring, sweet images that are expressed. Even the use of some expressions and sayings may signal the operation of defence mechanisms and in the obstetrics field there are a good many such "linguistic indicators". The birth is "the happy event", even though it is a concentration of intense affects and not only of happiness! Childbirth pains used to be called "pretty pain[2]", where it is difficult to account for the strange adjective, seeing such pain is similar to the anguish of dying. Often in the past the obstetrician could boast about having "delivered" of a great number of babies, as if the babies were not born, but their arrival was the work of a doctor (preferably a male!). The embryo and foetus – an incomplete being, still being developed and not exactly beautiful in purely aesthetic terms – is on the other hand already called and thought of as the "baby" in the mother's womb, loaded with all the sweetest possible metaphors. It would however immediately lose all attraction and human attributes as soon as any anomaly led to the (painful) decision to terminate the pregnancy. All these shifts designed to change the reality, to diminish some aspects (split and negation) and to idealize others, arise from the need to make working in contact with the clients tolerable, removing all the painful and potentially depressing affects. This strategy fails in the long term since, as it does not allow the affects to be encountered, it precludes all possibility of elaborating them. It is reasonable to presume that this task seems so daunting that one chooses instead a constant background of stress, perhaps diluted by frenetic, brainless industriousness.

Affects and obstetrics: the patients

The institutional functioning described above has found, in the last few decades, a collusive element at the social level due to the evidence of psychic disorders connected to the inability to interpret affects, in particular to the importance assumed in epidemiological and scientific terms by alexithymia. It seems to me that this contingent situation could also be expected to influence the expressions of malaise that (pregnant) women may manifest in the obstetric field and the way they are clinically interpreted.

Premature births and baby blues

Although it may be merely a coincidence, it is striking to see, for instance, that in recent years in particular in the United States there has been an increase in the incidence of premature births (Bydlowski, 2006). This increase has not been explained from the medical point of view and actually seems to be in contrast with the intensified controls and more and more refined diagnostic methods now common among the population. The pathogenesis leading to particularly early births comes about suddenly and does not respond to medical treatment. In some cases it is possible, through the psychological case acceptance of gestating women, to recognize a purely psychic aetiology, and with the psychotherapist's intervention, to guarantee that the pregnancy proceeds in a physiological way. It is usually the failure to elaborate family events, the death or disappearance without news of some relative, perhaps even of the grandparents' generation

[1] The term is used in the sense proposed by Jaques E. (1995). Social Systems as a Defence against Persecutory and Depressive Anxiety in Various Authors, *New Directions in Psychoanalysis*, Tavistock Institute London.

(transgenerationality), that finds expression in the pathology that places the unborn baby's life at risk. It is therefore crucial, firstly for the patient, but also for her family group, to be able to recognize repressed affects, interpret what is happening and trigger the distinction between remote biographies and the current one.
Another factor that, like the first, has recently assumed greater epidemiological importance is the phenomenon of 'baby blues', which seems to involve 50-60% of the population. It is marked by a general state of malaise and irritability and sudden mood changes. In this, the hormonal component is certainly a significant pathogenic mediator, but we must ask ourselves about the primary aetiology. There is however, no evidence to explain the greater incidence of this phenomenon in our times. The days immediately following the birth are psychologically very demanding because they require the woman to change her perspective from the relationship with an internal object (not just the baby in the womb, but the baby imagined and fantasized in the mother's mind) to the relationship with an external object, with a real baby, which states its needs and puts the mother to the test. On the other hand she changes her identity in a few hours, passing from that of the pregnant woman to that of mother, and also from a state of relative well-being (or of being used to the problems of advanced pregnancy) to a new state which, at least for a while, is certainly not optimal. The interest of the environment also changes, having first been directed at the "woman and her bump", now shifts sharply to the newborn infant.
The family members, all excited about the birth, usually do not understand the mother's sadness, which tends to be underestimated. Social changes may play a part in the higher incidence of this post-natal depression, since the woman may find herself more alone with less support from the family circle; however, the tasks the new mother has to deal with do not seem to have changed greatly over time. They are challenging also because they are represent substantial changes, in themselves, which appear relatively quickly, although, and this is the favorable element, they are not unexpected. It is therefore possible to prepare oneself to face them if one prepares internally and has the chance to meditate [to this end, Soulé (1990) praised the knitting of mothers-to-be!] and if one has a good emotional state, that is, "a certain degree of inner balance based on a baggage of good experiences [...] and of faith in good internal objects" (Salzberg Wittember, 1983 p. 23). As far as the patients are concerned, apart from the resources that people possess to different extents, the key element lies in the possibility of representing the new event to oneself, not so much in cognitive terms, but in specific, personal, affective terms. Awareness of our emotions, and permeability to our deepest affects are in this case too an element of protection.
A contribution in this direction can come from the family and hospital context – in the division and in prenatal preparation classes – which could support this work of elaboration by limiting the anxiety and worry that it is more difficult to express and deal with alone. Apart from commendable *ad hoc* projects, I think significant help can come from small gestures and brief phrases if the staff's mind is ready and able to interpret what happens and to feel it emotively. For instance telling a mother that in the little dress she made herself, the baby now really looks like hers and they are beautiful together, could help to acknowledge calmly the sense of extraneousness experienced at the birth and could suggest that it will be through what she is experiencing (the dress planned and made for him and now being worn) that a bond of affection will be forged.

Pregnancies and traumatic births in non primiparous women

I would now like to deal with the issue that I feel is emblematic in our discourse, that of pregnancies at risk in non primiparous women, using the contribution of Monique Bydlowski (2000). These women have already had a first traumatic birth and experience the next pregnancy with great anguish and risk for their own health and that of the unborn infant. Their first childbirth was very long and painful with a negative outcome, ranging from the presence of serious physical disorders to the death of the infant. The obstetrician defines the following pregnancy as high risk due to the possible repetition of the incidents that occurred in the first pregnancy, even without objective medical semeiology.
One element that I would like to underline is that suggesting a psychological reading of these cases, especially in the hospital institution that we have described, is not to be taken for granted. In such situations there are elements of concreteness, of such recent, real situations that they do not

seem to need other interpretations and hypotheses: the "facts" seem to already hold the explanation.
When one stops to look at some psychological characteristics shared by these women's' pregnancies, one sees that there was no worry before the first birth, which was seen as a natural event but was then experienced with unexpected drama. During the second pregnancy there emerge memories that evoke the first birth. The stories (and the memories) of the patients about the first birth show a three-way scenario, in which the patients are extremely dependent on the obstetrician, who is absent, and on an old midwife who intervenes in the patient-doctor relationship and does not help the mother-to-be. There are also, from the end of the seventh month, nightmares that repeat the previous experience. These dreams do not give rise to other associations: here too they seem to reflect the raw facts of reality, but they arouse so much fear in the patients that their sleep is disturbed, particularly when they are trying to fall asleep. It would seem that this clinical picture can be interpreted in the light of the concept of trauma and diagnostically defined as traumatic neurosis. Bydlowski in fact refers to the concept of trauma, in the sense of an "event in the subject's life, defined by its intensity, by the incapacity to cope with it adequately, by the disturbance and by the lasting pathogenic effects it causes in psychic organization. In economic terms the trauma would be a rush of agitation too great for the subject's tolerance and for his ability to dominate and psychically elaborate this agitation" (2000, p. 40). This is not an up-to-date definition, but it is in line with the Freudian elaboration of the concept of trauma. As well as the sudden excessive agitation, which cannot be eliminated with the usual means available to the subject and therefore foreshadows disorders in "energy functioning", this vision shows a fragmented action in the trauma, articulated in a first scene (model linked to childhood seduction) and a second scene, insignificant in itself, but which, by association, re-evokes the memory of the first. It is this first scene that unleashes such a rush of agitation that it overcomes the Ego's defences, but it is only after some time that the pathogenic significance is attributed to the first scene (*après coup*[3]).
This model seems to lend itself to interpreting what happens in the second pregnancy at risk. The first birth would be comparable to the first scene, while the second pregnancy would be the second scene experienced with anguish and nightmares because of the traumatic memory attributed to it in hindsight. The excessive agitation needed to bring about a trauma is given by the particular conditions of the mothers-to-be: pregnancy, characterized by "psychic transparency" (Bydlowski, 2004) places the woman in a position of fragility and psychic susceptibility, creating the conditions for the trauma to take place. The more intense the dreaming, the greater the vulnerability of the seventh month, and in fact this is when there is the highest incidence of premature births and when the symptoms of traumatic neurosis appear.
Bydlowski underlines that the women's' stories can be read as interpretations of the same basic script: the representations revolve around the themes of the primary scene and of incest. In the stories of the first birth, we can see the representation of the *imago parentali* embodied in the obstetrician and the old midwife: the mother (midwife) keeps the father (doctor) away from the daughter (patient), but the ban on incest has already been violated and the infant, who is its living symbol, meets with death or violence. Obviously these themes are known to our unconscious, being present both in the individual and in the collective unconscious. The crucial thing is therefore not the contents of these representations, but if anything, the work that is either done or not done on them, insofar as the affects tied to the representations are partially accessible and can be elaborated. The literature on pregnancy agrees on the psychic work that every woman has to deal with as soon as she takes on the identity of a mother. In this work there is the revisiting of meaningful steps of growth which together lead to the creation of the feminine, maternal identity (Pines, 1982, talks about pregnancy as the third process of separation-individuation) and so the relationship with one's own mother and the oedipal complex are central. The partial repression of these themes is shown by the mother-to-be's dreams, which are made quite explicit by psychic transparency, the widespread fear of childbirth, the sense of disgust the mother may feel at the first contact with the newborn infant's body resting on hers, and the disturbing similarity of the groans of labour to those of orgasm.

[3] Afterwards.

In women with a second pregnancy at risk there is probably a non permeability to these unconscious contents – shown by the lack of fear and of dreams – which, with no warning, emerge brutally with the first birth. Thus a sort of breach is created, a fissure from which in later pregnancies, repetitive nightmares which filter down. Unfortunately the oedipal and incestuous themes that are so explicit in the first birth are not spontaneously accessible for elaboration by the primiparous women because they are actually ascribed to the infant's body. Similarly to other psychosomatic pathologies, there is a sort of mental short-circuit that protects the subject "from recognizing a crime that is perpetrated unbeknownst to herself" (Bydlowski, 2000 p.45), but in contrast to those other pathologies, the non-mentalized pain is not ascribed to the mother's body, but to that of the infant, who is the glaring proof of the incestuous desire. The guilt is then projected onto the midwife and the doctor.
In situations like those described, various levels of psychological intervention can be hypothesized. One initial step is to share, in the obstetrics division, the idea of the existence of psychic dynamics (whatever they may be) and of their continuity with the somatic dimension (pregnancy and childbirth as psychosomatic events). Even when psychological interventions are not possible, an initial form of protection of infants and mothers-to-be can be put in place, connected to the possibility of planning caesarean sections, even when the indications are exclusively psychological.
Another level of intervention is found in the area of secondary prevention and can be considered as the case acceptance of patients with a particularly difficult, traumatic first birth. Another interesting area – of primary prevention – could be represented by pre-natal courses designed as a sort of psycho-affective support. In the group dimension, the emotions and affects involved in matters of human reproduction could be contained and protected, and the situations where this help is not enough could be identified. Subjects with very rigid defences, inaccessibility to certain unconscious contents or conditions of particular vulnerability might require specific ways (focused interviews, short psychotherapies…). It might also be useful to alert the obstetrics team beforehand for greater attention and care, in particular during the birth.

Affects and well-being

Beyond the specifically designed spaces and interventions in the psychological domain, we think there could be an important beneficial effect on the psychosomatic equilibrium of pregnant women if the overall functioning of the obstetrics division were permeable to emotions. A division in which the institutional situation revolves, not around the denial of affects, but around their acknowledgement, can not only foster the well-being of the staff, but play an educational role and promote the health of the clients. In particular, women in the period of pregnancy often experience states of psychic vulnerability and sensitivity to possible references – such as "good mother" models – which make them particularly receptive to what obstetrics staff convey to them. When facing new experiences like that of pregnancy, childbirth, illness, or miscarriage, the patients see the staff as "experts", not only in their direct medical responsibilities, but also in the human, relational, affective side of these events, having had professional if not personal experience. The way staff deal with and experience a particular situation can provide the clients with an interpretative key and can be seen as a model to refer to.
It is therefore wise to be aware of this responsibility and of the opportunities that it offers. For instance, when a foetus is lost or a baby still-born, if the institution is unprepared and perhaps discourages the identification of the infant and the rituals of mourning, underlining the woman's physical fitness for a new pregnancy, which is almost encouraged as a balm for the present pain, the message conveyed is that the only way of coping with pain is by negating and fleeing. Not to mention the risk for the psychic health of the next infant, which will be burdened with making the parents forget the dead baby, which since no proof exists, risks becoming perfect and incomparable. On the other hand, if the institution is able to provide words for the pain, to offer space for thought, is able to take its time and to support silence, it will teach parents that pain can be contained and understood, that it is truly great, but that there is still space for other affects. This applies to the patients, but also to the staff!

Apart from rather specific situations of suffering, one must not forget the vast majority of people who experience pregnancy and childbirth with no complications from the medical point of view. These people, too, go through emotively dense and challenging experiences which, depending on how they are experienced and elaborated, can enrich the person of impoverish her and complicate the relationship of caring for the infant. The importance of expressing the emotions in the obstetric domain is shown also by empirical studies. It is recognized for instance that the reflective function that may be more or less developed in the mother-to-be has the effect of protecting the foetus from stressful stimuli (Monk, Sloan, Fifer, Myers & Bagiella, 1996). The protective effect of expressing the emotions has also been shown in terms of the symptomatology of post-natal stress. Bucci, Solano, Donati e San Martini (2005) argue that spending 20 minutes, in six sessions, between the 7th and 8th month, writing emotions and thoughts on the pregnancy, leads to a lowering of the level of alexithymia and positive effects on depression symptomatology, psychological well-being and the perception of pain during childbirth. Di Blasio and Ionio (2001), on the other hand, point out that writing a short report of one's own childbirth two days after the event, using the Pennebaker model, facilitates the elaboration of contents of "avoidance", which cause feelings of closure and anxiety, and leads to the immediate reduction of the symptoms of anxious hyperactivation.

The results of this research have not however been transformed into widespread assistance practices, despite the clear advantages and the relatively low cost. I feel that one of the reasons why this opportunity has not been taken up is connected to the difficulty of taking the affective aspects into due consideration. It is no coincidence that in recent years the preference has been to invest public money in providing free epidural analgesia during childbirth. After all, this is generally offered as a simple medical procedure which there is no need to worry about, although two slightly different messages are actually conveyed by the doctors themselves. On the one hand, the choice seems to be between wanting to suffer when giving birth or to give birth painlessly, while on the other, it seems to be the preferred procedure for women who cannot stand pain. Keeping in mind that it is electively offered to women at their first birth who could put up with a longer labour, it is hard to see what parameters a person has to know if she will be able to face childbirth pain; however, the message sent is discrediting and disparaging, and risks colluding with the fear that a woman normally feels – not only physically – before such a momentous event as giving birth. The alternative is therefore to see oneself as masochistic – I want to suffer when I give birth – or incapable – I am not able to give birth without painkillers! In fact, apart from the actual innocuousness and efficacy of the epidural analgesia, what is offered is a highly medicalized birth, after years of promoting the active role of the woman, and a birth from which much of the emotion and the affects normally present are excluded, or one could rightly say, anaesthetized!

It also seems opportune to recall that obstetrics divisions deal not only with the meaningful but circumscribed experience of childbirth (although memory does not measure time and the memory of the birth remains a part of us!), but it is here that the mother meets her child. It is here that the first post-natal exchanges take place, the first extremely important relating between infant and parents, the first experiences of breast-feeding, the first olfactory, tactile, and visual discovery of each other, in other words, all experiences that continue, just as the relationship continues. These are often unforgettable, thrilling and mainly joyful, celebrative moments, but they are not the only emotions. The meeting with the newborn infant is a meeting with a largely unknown being, but one that for most of the time will determine the mother and father's rhythm of life. His sleep, his hunger, his needs will supplant those of his parents and this will not always be without pain, aggressiveness, exhaustion, doubts and sadness. In childbirth the presence of aggressiveness and love is intense and also physically felt; later, when the physical pain has vanished, the feelings do not evaporate. In their inability to approach and recognize emotions, women have an image of motherhood, also in obstetrics divisions, that appears to be an idealized and mystificational exaltation of the perfect mother, sweet and happy; it will certainly be more difficult for them to recognize the ambivalence of the feelings that tie every mother to her child and to elaborate them, constructing an authentic relationship that can promote mental growth.

The failure to recognize the affects can herald a pattern of avoiding attachment and alexithymia: a mother who does not know how to listen to her own affects, may become a mother who cannot recognize her child's emotions and is not good at teaching how to interpret emotions and fostering the development of the ability to reflect (Fonagy & Target, 2001). In this case the search for increasing attention from a medical point of view and the decision of many obstetrics divisions to

favour the early infant-caregiver relationship (eg. rooming in, encouraging breast-feeding on request, space and time for infant-parent intimacy…), in the awareness of the fundamental importance of this for the infant's psychophysical well-being, would prove to be if not useless, at least contradictory.
We believe that the crucial point lies in the ability of the staff and of the division to present ways of functioning that take into account and valorize the emotions and the affects of all the subjects: this substantiates relationships and enriches the meaning of every encounter. This is what our health depends on!

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