SHARING SPACE: Obstetrics and Attachment

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Full Text: Headnote ABSTRACT: In the last 30 years there has been an increasing amount of psychological investigation into attachment. At the same time there appears in this literature to be a gap in the discussion of what may be the origins of early detachment of the child from his/her caretakers. This article suggests that the beginning lies in obstetrical care in today's highly interventional and technocratic management of pregnancy and childbirth. Specifically, what drives this situation is the attempt of obstetricians and medical professionals to avoid the highly litigious system. The result of the effort to reduce risk at all personal cost, creates a stressful situation for the mother and decreases the emotional satisfaction of the family. In short, the power of birth has moved to the professional and remains causal in dis-attachment of child to parent. KEY WORDS: Attachment, obstetrics, prenatal, pregnancy INTRODUCTION All attachment begins in the womb. We consider the time of postpartum as crucial for attachment. It is natural then that we examine how interventional obstetrics might affect the attachment process. For example, medical/technological interventions such as epidurals, inductions and C-sections may carry a much higher implication than previously thought. When a therapist is considering attachment disorder, especially when "... that attachment is a measure if a child's experience... ." Daniel Siegel, M.D. also has said, if"... .the parent creat[es] a state of alarm in a child [or fetus, author's insertion], the child is presented with a "biological paradox': its brain motivates it to move toward the caregiver for soothing ..." on the one hand, but if the caregiver is the source of the state of alarm, the attachment is an intrauterine "Catch 22." Going to the labor room is informative to make this point, but going into the doctor's office is even more illuminating. Karen [Karen will represent every young woman in her first time pregnancy] comes into the examining room excited about being pregnant. This, her first contact with the medical birth assistant, was a time for conformation, for encouragement and for education, as Karen wants to do everything she can for her developing baby. And then first shock comes. The visit is all about her risk factors. In detail the nurse goes through a listing of every concern in her history, that of the father of the baby, drug and alcohol use, her family history of genetic conditions, and on and on. Toward the end of the interview she asks if she is to see the doctor and receives the disappointing news that she will not see him until her next visit. "After all," nurse says, "Doctor needs to have the ultrasound work and the laboratory testing so he can evaluate the pregnancy. You understand?" Karen did not understand, but being afraid to argue accepted the explanation and made her next appointment, a whole month away. When she got home her excited husband was disappointed, too. He wanted to know that she was all right and that their baby was okay. When he realized how long before they could have conformation, another month, and meaning she would be almost 17 weeks according to their calculations, he thought maybe something was wrong with her and did not hesitate to question her. That brought on all kinds of worries, as she related what had transpired in the office, especially, the digging into their history. "Do you suppose something is wrong with us and the baby is not normal?" they wondered. Instead of attachment to their growing child there was fear, deep fear, and doubt about their ability to have a normal child. Now too, the couple was becoming dependent on the medical profession for reassurance and care, willing to accept anything so that their baby will be "Okay!" Thus it begins. Karen goes to the laboratory (blood and urine tests) and the sonographer. She asks for the results but is told they aren't allowed to give out results and she will have to get her information from her doctor. Now she knows something is wrong otherwise "they" would have told her. Watching the ultrasound is almost impossible because the technician turns the screen away. The technician signals for the doctor to come in and they look at what is on the screen. And Karen asks, "Is there something

wrong?" She gets the same response, "You need to discuss the results with your doctor at your next appointment." "John, I know something is wrong with our baby," Karen cries, as she tells him what had happened. She remembered that one of her grandmother's children had died at birth. This thought with all that she has gone through to date puts even more fear into her at that first visit. / know they saw something on the ultrasound but would not tell me what was wrong. "John, I can not have a damaged baby, I just can't." They called her obstetrician after a couple of days of pain and fear imagining all kinds of disasters. They had considered abortion, but let that go. Karen felt unattached to her baby now in an unconscious act of self-protection-If I don't admit its there then nothing can be wrong. The office receptionist told her she would have the doctor call, so for two anxious days they awaited the conformation of their worst fears. Note that they had now switched to fear rather than happiness about their baby. The course had been set for anything that the professional wished to do. Mother will wish only the best for her baby and herself. There is a psychological issue inherent in mother's mind. That is, "Can I have a normal baby." I know this because regardless of the culture the first question I hear at the time of a delivery is, "Is it normal?" You may think that this is uncommon and I am sure that if I showed this article to 100 doctors and nurses they would consider it a fantasy. Well, it is not fantasy I assure you. In my years of obstetrics I saw many women who had been frightened just this way when they began their journey toward having a child. Today this is a common denominator. It is not that the profession is unconscious of the effects of their failures in this early contact with mothers, it is their fear that they will miss something and be sued. (The most common cause of lawsuits is missed diagnosis.) Obstetrics has become adversarial-us (doctors) against them (patients). The result is babies who are permanently disassociated from their parents, programmed to feel unwanted, angry and resentful even before they have reached viability in the womb. Dis-attachment! That may be the beginning of the baby's problem. Karen was relieved, sort of, when her doctor finally told her everything was normal. But that little grain of self-doubt had been inculcated into her sense of self-worth as a mother. Birthing During the last months of pregnancy, Karen anticipated every visit seeking reassurance that her baby was normal. Ultrasounds and nonstress testing seemed always to be okay, but there was so little time to speak with her doctor, who rushed in listened at her swollen belly, poked around and said things seemed fine, scooting out of the room before she could reassure herself. She had to assume her baby was alright, but that little seed of doubt had been building into a larger plant, one that she dreamed about, one that kept her awake and that kept her isolating herself from the baby. At the same time she felt it move and just knew that "it was going to be okay". But was it? At 36 weeks, four weeks from her due date, her doctor said something that put her fear into prospective. "We might consider getting this baby delivered early, say in a couple of weeks." "Why is something wrong?" "Not really, it is just a precaution. You know most babies get in trouble in the last weeks and we don't want that, now do we?" and out the door he goes. Karen talks about it with her husband, and friends who have had babies (definitely not reassuring to her), and all agree that there must be something wrong since that should not happen in a normal situation. In a panic Karen would agree with anything now. She calls the doctor and schedules delivery at 37 weeks "just to be on the safe side". The doctor now goes the next step-maybe, "We should just go ahead and do an elective section, your baby is a little big." That cooks it! Diagnosis confirmed-there is something wrong! The story of a Karen represents the greatest majority of women approaching medical management of pregnancy in the USA since 2000, maybe even several years before that. Statistically, hospitals who consider birthing departments, and many have given them up because of the law suit risk, now permit elective inductions and elective cesarean sections. The three synchronistic interventions that cause birth trauma and shock are: induction and augmentation with uterine stimulants, pharmacological analgesics and anesthetics, operative vaginal delivery and cesarean sections. When the induction of labor and cesareans are elective the issue is compounded for the baby. (See Emerson, Obstetrical Interventions.) Today in multiple hospital labor rooms elective induction averages 50-65%, epidural anesthesia 80%, elective cesareans 45%, and indicated cesareans 35%. The baby is handled as a product, sent to the nursery and taken to mother only at the connivance of the nursery

personnel, discouraged from breast-feeding and the males get circumcised routinely. Mother, father and family are isolated from the child who is exposed to kind but unloving hands, and placed on a hospital schedule for feedings, "non-nutrient pacifiers" are stuffed in their mouths to keep them quiet. Socialization is to the hospital, not the society of the family; all of these events can not help but impact attachment. These then are the pressing problems for the child as well, birth trauma and shock, effects from anesthesia, cesarean section trauma, feeling/being unwanted and exposed to maternal fear. Instead we must recognize that the child has no choice but to be selfprotective, to survive mother's fears and doctor's and hospital's need to control childbirth. At the end, Karen looks to her doctor and thanks him profusely for her normal baby, he saved it in her mind and without him or her she would have been rift in her outcome. But under it all Karen is unsatisfied with her experience, and deeply disappointed in herself. What a shame! It did not have to be that way. Summary Every professional who is interested in attachment theory and therapy needs to work hard toward correcting the problem at it root, during pregnancy. It is not too late to be sure every baby born is carried in an assured uterus, with a supported and happy mother, and is welcomed into the world as a feeling, conscious being. Just imagine what that would mean for the baby's future and that of mankind. AuthorAffiliation Robert J. Oliver, MD, PhD AuthorAffiliation Robert J. Oliver, MD, PhD is a retired Obstetrician and Gynecologist. Also a Sexologist/ Gestalt Psychotherapist, he currently resides in Arizona. Correspondence about this article may be sent to 3734 East 4th Street, Tucson, Arizona 85716. Email: docohver@aol.com.

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