

The Role of Emotions in Pregnancy and Delivery

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Throughout the ages and among all peoples the expectant mother has been looked upon as something special. Whether, as in some primitive cultures, men detest their wives for being pregnant, or, as in most cultures, they feel awe and respect in the face of the mystery connected with the creation of a new life, the pregnant woman has been accorded a special role.

There has always been a notion that the woman's state of mind during pregnancy has a bearing on the infant, and this notion has given rise to all kinds of superstitions: Pregnant women should be spared excitement; they should not see a fire; they should not be bitten by a dog so that the child will not be born with a birthmark; they should not get their teeth pulled so that they will not miscarry, etc. Although it is mainly physical injury and disfigurement people have feared, they have realized that mind and body are a unity and that (mother and baby being one) through the mind harm may be transmitted to the body. While they were aware of the fact that the mind of the mother has an influence on the baby, they did not fully realize, however, that the emotional state of the mother also has an influence on the pregnancy and delivery proper.

Pregnancy always produces a great variety of emotional reactions in the expectant mother herself and in her family. (The attitude of the family has a considerable influence on the course of the woman's pregnancy and to some degree also on her labor.)

Even when a pregnancy is planned and the child is accepted and very much wanted, there is always some fear and anxiety present. This anxiety in the woman may concern either the baby or herself.

Regarding the baby, there is the doubt as to whether it will be physically and mentally normal.

Regarding herself, there is the question of intensity and duration of labor pains, some fear of permanent damage to her health, to her figure, fear of the responsibility in rearing a child, etc.

Although all women undergo the same endocrine as well as anatomical and physiological changes during pregnancy, the physical man-

ifestations are different in various women: While some claim that they never felt so well in their lives, others show specific symptoms in various degrees, from mildly increased salivation, frequency of urination and "morning sickness" to severe toxemias. These facts indicate that factors other than mere physical changes must be involved. In nausea and vomiting, for example, the following contributing factors may be considered:

(1) *Organ inferiority*. It is assumed that during the first trimester of pregnancy extragonadal tissue edema can be produced due to a change in the estrogene-progesterone balance. These edemas also appear in the mucosa of the gastro-intestinal tract. Women who show *a priori* inferiority of this tract may respond to the change by nausea and vomiting until the balance has been restored at the beginning of the fourth month.

(2) *Emotional factors*. Slight symptoms of nausea and vomiting during the first trimester, however, should not be considered pathological. The well adjusted, healthy woman is not unduly bothered by them and does not use them as an excuse for withdrawing from her duties. If, however, vomiting becomes excessive or continues beyond the first trimester, and in spite of medication even increases in severity (this being the only sign of a toxemia when all other findings are normal), then we are entitled also to suspect an emotional cause.

Examples: A 35-year-old woman (Para I, Gravida II), who lived in crowded quarters with her in-laws with whom she did not get along, had to be hospitalized twice, and each time within one or two days after admission her vomiting stopped after a minimum of medication. During her second hospitalization she was made aware of the fact that she used her vomiting and the resulting misery as a weapon against her in-laws. Once she was able to accept this explanation she no longer felt the need for excessive vomiting.

In contrast, another woman, age 22 (Para 0, Gravida I), vomited continuously and refused to eat until hospitalization was strictly indicated. However, the day before she was scheduled to enter the hospital she ate the food her sister had prepared for her and kept it down. From then on she vomited occasionally but not excessively.

(3) *Psychological factors*. Nausea and vomiting seem to be accepted as symptoms of pregnancy mainly by peoples of the industrial civilization. The incidence is low among Eskimos and native African tribes, and true hyperemesis is rare among Southern Negroes. The same is true for the American and Mexican Indians as long as they

live in their familiar surroundings. But when members of these groups become assimilated into industrial civilization with its greater stress and strain, symptoms of nausea and vomiting appear in early pregnancy and "morning sickness" is accepted as one of the "signs and symptoms" of pregnancy.

It was very interesting that during my three years of work in the outports of Newfoundland there was not one case of pernicious vomiting among the women who had pre-natal care. All the primigravidae had completely normal pregnancies and were in very good health and high spirits. But the multigravidae frequently showed mild signs of toxemia which could usually be explained primarily by physical as well as socio-economic reasons.

The women in these outports of Newfoundland are intellectually as well as emotionally on a rather childlike level, full of fears and anxieties centering mainly about their health. But there is no confusion about their feminine role. They marry out of love and there is usually a good relationship with their mothers as well as with their mothers-in-law. They know that they want to get married and have children, and that is their only goal in life even if they plan on teaching or nursing prior to marriage. Expecting a baby in these outports puts a woman very much in the center of attention and increases her status. Many have "morning sickness" but they consider this a normal symptom of pregnancy.

They deliver without analgesia and without anaesthesia, their only security being the presence of the people they trust most sitting with them, holding their hands, stroking them, and trying to cheer them up. But they are terribly afraid of pains, they cry and yell, especially during the first stage of labor, which is frequently quite protracted. However, as soon as the second stage sets in they become very cooperative, with the result that this stage is usually relatively short. There is, however, a comparatively frequent delay in the third stage.

At this point I should like to give an example that shows how much mental readiness for the delivery itself influences its course. A 25-year-old woman (Para I, Gravida II) called for me because she started to have pains. She lived in the house of her in-laws and there was much commotion in the house throughout the day. The woman was quite irritated by the goings on, her pains were short and sharp at irregular intervals, and it was not until evening, after the house quieted down, that labor actually began. Suddenly she heard her little girl crying in the bedroom upstairs. At that she said: "My little girl is crying up-

stairs for me to kiss her good night. Please let me go upstairs, so that I can get my peace of mind. I cannot deliver while my mind is uneasy about my little girl." On her return she said, "Now I am all right." From then on labor progressed rapidly, and in about an hour and a half she had her baby.

The women, without exception, are ready to nurse their babies, and, although they are very poor and not adequately nourished, they usually have enough milk. Sore nipples are rare; occasionally one nipple becomes a little sore for a few days, but usually the breast can soon be used again.

In contrast to the comparative uniformity of reaction in these isolated settlements is the great variety of attitudes in patients in a prenatal clinic or obstetrical ward of a large American city. Here one finds that women who are generally mature show the same maturity in their attitudes toward pregnancy and delivery. Some women with various physical ailments go through a relatively uneventful pregnancy merely by availing themselves of all the medical facilities at their disposal and following the physician's advice. Their delivery may be simple or more complicated, but their attitude toward it is not characterized by additional anxiety because of their physical handicaps.

On the other hand, women who always have been spoiled children and remained that way even after they got married reveal an entirely different attitude. Because they are young and healthy and receive much attention and derive other satisfactions from their state of pregnancy, the pregnancy itself may be uneventful; but as soon as labor starts their faulty style of life has a bad effect on the course of the delivery. Frightened to death, they fight off the effects of medication and are tense, continuously noisy and completely uncooperative. Thus, labor is unnecessarily prolonged and after it is over the women are exhausted. It is only now that they permit the medication to take effect and they usually sleep almost continuously the following two days.

During the course of pre-natal care the obstetrician's role becomes paramount. The obstetrician represents a father- or mother-figure and can greatly influence the mother-to-be in their attitudes toward pregnancy and delivery. The doctor can help a woman to overcome her fears connected with pregnancy and delivery, can guide a rejecting mother-to-be so that she will accept the future baby and even look forward to the arrival of the new little human being. Quite frequently, under the guidance of a psychologically inclined obstetrician, women who first reject being pregnant become progressively accepting of the

fact and show more maturity in their attitudes toward their pregnancy as well as toward labor and the expected baby. They gain enough self-confidence while the pregnancy progresses to take the responsibility for bringing up a child.

Equally important and educationally beneficial is the fact that through regular visits at the clinic the women get well acquainted with each other and have a chance for mutual encouragement. Even before it is explained to them by the doctor they already know from other women that no medication is given before labor is well established. Having the reason explained to them, they are ready to accept this procedure.

If, however, a woman tries to make her obstetrician promise to give her analgesics immediately at the onset of pains, she shows that she is not ready to take any responsibility for herself or for the expected baby. In cases of this kind it is especially important that the obstetrician be psychologically trained so that he can help the patient during prenatal care to give up the immature attitude which induces her to endanger herself and her baby's health rather than cooperate in a situation of which she is irrationally afraid.

Women in labor depend greatly on the presence of the obstetrician throughout the course of delivery. Many call constantly for their favorite doctor and quiet down only after he or she appears. For example, one primipara entered the hospital early in the morning in mild labor. Since the doctor had to be in the clinic she could see the patient only twice during the morning for a short rectal examination but promised to stay with her as soon as the clinic was over. The last time she examined her the patient was almost fully dilated. On her return from the clinic about an hour and a half later, the young student nurse who had administered medication and stayed with the patient was quite discouraged: No progress had been made; the woman did not want to bear down and behaved uncooperatively. However, as soon as the woman heard the doctor's voice she regained her security and became very cooperative; and the baby was delivered by simple episiotomy in due time. After everything was over the little nurse remarked: "This baby was really delivered by psychology. If you had not come, it would have been a mid forceps."

In the cities there is much greater resentment against breast feeding. Nevertheless, if there are several women in the ward who want to breast feed their babies the others often follow suit. If, however, some refuse it violently many others adopt the same attitude. It is usually

those in whom it is discouraged because of their own physical condition who want to nurse most. Sore nipples are quite frequent and very often breast feeding must be discontinued because of lack of mother's milk.

Summary: The course of pregnancy, delivery and the post-partum period is greatly influenced by a woman's style of life. The more mature a woman, the greater her acceptance of her feminine role, the greater is the possibility (provided there are no other physical handicaps) that it will be normal. According to Alfred Adler, a person's style of life is put to test in times of crisis. If this style of life is far off from the road of social living, it is the thrilling and gratifying task of the obstetrician during pre-natal care to help a woman change her style of life, mature and accept motherhood as the most fulfilling experience in a woman's life.

A N N O U N C E M E N T

We have been advised that the New York State Department of Mental Hygiene has approved the issuance of a license to the Individual Psychology Association of New York, Inc. to conduct a Psychiatric Clinic at the Alfred Adler Consultation Center, 333 Central Park West, New York 25, N.Y.

The official opening of the new Psychiatric Clinic will be announced shortly.

The Medical Director will be Alexandra Adler, M.D. Mrs. Danica Deutsch will be the Executive Director and Mr. Ernst Papanek, Co-Director.

So far the following psychiatrists have agreed to serve:

Kurt Adler, M.D.

David M. Bressler, M.D.

Frederic Feichtinger, M.D.

Joseph Meiers, M.D.

Helene Papanek, M.D.

Oscar Pelzman, M.D.