The parental couple and the group of caregivers in the care given to the baby: hypochondriac mirrors

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Abstract

The parental couple, the group of perinatal and early childhood caregivers, are subject, in the care given to the baby, to ordinary hypochondria. Taking care of a baby, a subject who does not yet speak verbally, requires work on interpreting his various signs, especially bodily ones. If the primary parental preoccupation, the primary caring preoccupation are in play, our regular clinical work in nursery, led us to propose a primary hypochondriac parental preoccupation, and a primary hypochondriac caring preoccupation. In this sense, the members of a group of caregivers offer a real welcome and treatment of the hypochondriac preoccupations of parents.

Key words: baby, parents, caregivers, nursery, parental hypochondriac preoccupation (primary)

A good enough hypochondriac preoccupation

A *good enough hypochondriac preoccupation* (Stathopoulos, 2012b, p. 188) remains active in us throughout our life, intrapsychically, intersubjectively, in our families, in our membership groups. In its extreme poles, this hypochondriac preoccupation oscillates between *too much* and *not enough*. Too much research for care results in too much medication, paramedical and medical consultations, and even *surfing* on websites. *Not enough* rhymes with not seeking care despite the signs, with the vital risk that this could involve. The covid-19 crisis has, it seems, perfectly illustrated these two poles.

Between these extreme poles lies the challenge of being for oneself, and for another, *good enough hypochondriac mother*. In our opinion, a hypochondriac maternal preoccupation is rooted in a primary hypochondriac maternal preoccupation, specific to the perinatal and early childhood clinic, from the time of pregnancy to that of the baby.

Hypochondriac hypersensitivity, from Winnicott

For Winnicott, the "ordinary, normally devoted mother" (1949, p. 54) must be able "to adapt to the very first needs of the newborn, with delicacy and sensitivity" (1956). *Primary maternal preoccupation* is an "organized state" of hypersensitivity comparable to a state of ordinary madness, of "normal illness", subsequently removed (1956, p. 40-41). Winnicott mentions: “(I use the word 'disease' on purpose, because a woman must be in good health, both to achieve this state, and to be cured of it when the child delivres her from that demand. If the child were to die, the mother's

condition would suddenly turn out to be pathological. This is the risk she runs.) (p. 41) (1)". The real and fantasized risk of the *infans's* death is what potentiates and develops a *primary hypochondriac maternal preoccupation*. For Winnicott, "Only a mother sensitized in this way can put herself in her child's shoes and meet his needs. They are first of all bodily needs which are gradually transformed into needs of the self, as a psychology emerges from the imaginative elaboration of the physical experience" (p. 45).

For each parent, fears related to the somatic survival and good somato-psychic development of their child begin with the desire to have a child and are then found from conception to the very first days of life. The worry of the mother, the father or any other caregiver, which are the caregivers, including the therapist, for the existence of another is the "basis" of the feeling of existence of the latter (Stathopoulos, 2012a, p. 309). The hypochondriac preoccupation of the parents creates the baby. This preoccupation is generated by the state of *absolute dependence* (Winnicott, 1963) and original distress (*hilflosigkeit*) in which the baby finds itself within his environment.

To a *primary paternal preoccupation* (Delaisi de Perseval, 1981, p. 145, 152, 243), we propose a *primary hypochondriac paternal preoccupation*. In neonatology, for example, it has been observed that fathers monitor the urinary function of their premature child in particular when mothers are more preoccupated about oxygen supply (Birsan, Lacaze, 2012). By this hypochondriac tuning, mothers and fathers would have different types of hypochondriac preoccupations.

Also, still drawing on Winnicott's work, he reminded us that "for a woman who has a strong masculine identification, this part of her maternal function can be especially difficult to achieve, because the removed desire of the penis leaves little place for primary maternal preoccupation (1956, p. 42)". Later in his work, he specifies: "In the mother, I always understand the father" (1962, p. 29). So, how to think of a primary paternal preoccupation for the mother and a primary maternal preoccupation for the father? Following these proposals, we question a *primary parental preoccupation,* echoing the concept of *psychic biparentality* (Ciccone, 2014, p. 74). The *primary hypochondriac maternal preoccupation*, and the *primary hypochondriac paternal preoccupation*, would be the "two poles" of what we suggest to be called the *primary hypochondriac parental preoccupation*, which is supported by a *primary hypochondriac bisensual preoccupation*.

Thus, the primary sensual integrations are questioned, in their always singular results of the psychic treatment of this *primary parental preoccupation*.

Parents and caregivers: hypochondriac mirrors

In our contemporary societies, we have to question the concern to medicalize and paramedicalize pregnancy and childbirth (Missonnier, 2015b) as an established *hypochondriac concern.* Ultrasounds feed the hypochondriac concern of the parent(s). They respond to fears of malformation(s), handicap(s), disease(s), and

would be an objective witness of the *good enough* physiological development of the fetus (Soulé, 2001). Around childbirth, the mother may fear dying herself, that the baby will die, the father is also worried about them, with the hazards that this experience represents. After the birth of the baby, the young parent(s) is preoccupated about the good physiological state of their child, looking at him in all his colors, his limbs, his reflexes, the continuity of his needs bodily (hunger, sleep, urine, stools, etc.). These needs will be a real preoccupation, which can be found in maternity, at home, in ehe nursery (issues of transmission between professionals and parents in times of separation/reunion) or at the maternal assistant.

The embryo, the fetus is intrinsically caught up in the (in) the games of hypochondriac and psychic (res) feelings of his parents, of his gestators - if we consider the pregnancy of the father - and of his future parents, in a *always* special environment. Following Szwec (2002), we propose that *the child is the hypochondriac organ of his family body*. Winnicott used this example (1948, p. 60): "When I started out, I saw a little boy come to the hospital all alone and say to me: *Please, Doctor, mum has pain at "my" stomac*, which drew my attention to the role the mother can play." The depression of the mother of this child was thus expressed by the use of a hypochondriac symptom.

His own body, the body of his partner, the body of the baby, can be experienced as exterior(s), as strange(and)ness (Freud, 1919; 1925). Somatic and psychic experiences are like *matriochkas* (Missonnier, Kelalfa-Foucaud, Boige, 2002, p. 82-83): they box inside each other to disappear into each other, and this, at all ages of the subject's life. Specifically, the embryo, the fetus, erupts, like an *intruder, even* a *monster,* an *alien*, into the psychic and bodily life of his parents, parents and environment. The embryo that has become a fetus, then a baby, child, adolescent, *adulescent* (a portmanteau word designating the more adolescent subject and not yet an adult, remaining dependent on his parents), young adult, adult, finally senior, has lived and lives his own body, as a strange "image reflected by the mirror" (Freud, 1919), a mirror which is much more than a simple scopic mirror (Pasche, 1971).

This "radical strangeness" of the discovery of our body, which sometimes "we [discover] almost in a persecutory mode", creates a "threat of a strangely" between psyche and soma which favors "a start of first self-awareness. "(Villa, 2004, p. 125). This brings us back to this hypothesis of Stathopoulos (2012, p. 555): "the way we first perceive the body is generally hypochondriac in nature". This differentiation between the inner world and the world exterior, at the source of impulses, is originally hypochondriac, in the baby and in his hypochondriac mirrors that are his parents.

According to Winnicott, "Strictly speaking, there is no clear line between the overt hypochondria of a depressed mother and the preoccupation a normal mother has for her child. A mother must indeed be capable of hypochondria if she wants to be able to detect in her child these symptoms which doctors ask about in an attempt to cure the disease early "(1948, p. 84). *Sufficiently* hypochondriacal parents are cenesthetic

mirrors and therefore hypochondriacs: they “play” at “apprentices” nurses, pediatricians, educators and “shrinks”, among others.
Doctors (general practitioners, obstetrician gynecologists, pediatricians, etc.) are in essence hypochondriac mirrors (Fédida, 1995; 2002). However, they themselves *complain* of consultations requested by parents appearing to them *a priori* "for nothing", of hypochondriac mothers, overwhelmed in their experiences around their pregnancy, with their baby, no longer knowing how to distinguish between things. real somatic, psychological *and/or* fantasized. Sometimes, a somatician could well make a diagnosis, to meet the requirement of a diagnosis on the part of the patient and/or not know how to recognize his limits, his impotence, when in other situations this impotence by ignorance brings the somatician too quickly to say that "it's in the head". This could have the effect of crystallizing through somatic research a hypochondriac complaint that has moved there and then lost, making him "imaginatively" sick. There is the risk of mistaking hypochondria for a joke, like Molière's *imaginary invalid*.
Another form of hypochondria would be that which can lead to becoming ill (imaginary) instead of, by substitution, with, in the extreme, simple Münchausen syndrome or by proxy (Belot, 2009).
At the extreme, there is the search for oneself, for and by another for a hypochondriac mirror.

The mother of Octave and Olivia

With Winnicott (1948), we believe that a nursery team can accommodate and address the hypochondriac preoccupations of mothers and fathers, provided they are embodied in a hypochondriac caring preoccupation.
Parents' discussions with professionals during daily reception times at the crèche (so-called "transmission" times) are often centered on the child's physiological state: sleep, meals, sphincters, etc. The younger the child, the more this interest is important among parents, among professionals, according to our observations.
Using the Bionian model (Mellier, 2004; 2005), we argue that the *body-group-crèche* has an essential function: that of being a receptor and detoxifying potential of the hypochondria of the families accommodated within it.
We will take an illustration of this here: that of Octave and Olivia's mother.

Clinical interview and informal discussions with the mother

The psychologist receives an interview at the crèche with an obese forty-two-year-old mother, five months pregnant, already the mother of two children.
Olivia is nine, Octave is three. At the nursery, he shows difficulties in integrating the limits, which led the mother to request an appointment with the psychologist.
Regarding her current pregnancy, the mother mentions "a denial of pregnancy": she did not realize "until three months of pregnancy". The mom had returned to college and "the end-of-year exams took precedence over everything else." The

announcement of this pregnancy forced her to suspend her much-hoped-for studies which she had just started a year ago. She worries: will she be "able" to resume the next year, when her child is nine months old?
A different positioning of the parents on the boundaries around Octave is revealed: maybe because he is the youngest, maybe because he is a boy. The older sister, Olivia, nine years old, takes back her brother a lot, "she is like a mother with her brother", confides the mother. Sometimes Olivia "takes her brother across" on the zebra crossing.
According to the mother, it is the two miscarriages between the birth of her daughter and that of her son that would justify their differences in age of six years.
She evokes a dream: she dreamed of being "pregnant with twins" and does not know what to think. The psychologist offers her an interpretation: "Could this dream of a twin pregnancy reflect the desire to find her two unfulfilled children?" perhaps?". Immediately the mother nods, appearing happy, as relieved by this proposal.
She talks about another change coming: The family will be moving soon, in order to have a new room for the baby, which will force Octavian's older sister to change schools during the year.
A few months later, the psychologist sees Octave and Olivia's mother again when she arrives in the hallway of the nursery with her son, a few days before his birth. She appears outdated. She breathes, exhausted by the weight of her obese body, from the end of her pregnancy, by the challenges of her son. It's hard for her to sit down, to bend down. As she asks Octave to undress alone, to take off his shoes, to put on his slippers, he does not respond. The psychologist hears the mother's need to intervene, to support her, to relieve her. He then offers Octave to accompany him. Thus, Octave responds to requests and the mother will be able to lead her son in the unit of adults.
When the mother goes out in the corridor of the nursery near the exit, she confides to the psychologist that "Octave is difficult at the moment", "after the move, with the pregnancy", "yet he talks about the baby", " he wants to caress his mother's belly ". The mom is "feeling a lot guilty right now" about those "last moments without the baby to take care of." She "passes" on the rules because of this, but also because, physically, she can no longer. She sits in the hallway during this exchange, waiting to leave when she has regained "strength and courage."
She talks about her blood pressure, her blood sugar, which she is very worried about. She will soon have a blood test. She is very worried about the arrival of this new baby, with this birth approaching. The psychologist hears the fear of losing this soon-to-be-baby fetus, as was the case during her two miscarriages. For a brief moment, he imagines taking her to a doctor or pharmacist to find out her blood pressure, her blood sugar.
She thanks him very much for his help with Octave, for his listening and leaves the nursery.

The director of the crèche comes to meet the psychologist after having observed them. She confides that she can no longer bear the complaints of this mother and finds her intrusive.
A few days later, the mother gives birth: the baby and the mother are doing well. Octave will be somewhat "jealous" of this baby, not wanting to look at him when they first meet. The second day, before going to the maternity ward with his sister and dad, he will express, according to the mum, his desire to “see baby”.

Hypochondriac defect, advent and excess

In the mother of Octave and Olivia, her two miscarriages, in our opinion, question a *hypochondriac defect*. The difficulty in feeling pregnant and discovering her fifth pregnancy at three months, questioned us as follows: did we have to wait three months to be certain that her fifth pregnancy was going well, according to our hypothesis? Here we hypothesize a *hypochondriac advent,* when hypochondria becomes sufficient for it.
In contrast, we will find *excess hypochondria* in this mom as she looks ahead to childbirth, along with her worries that this pregnancy will end badly. Thus, we will understand her exchanges with the psychologist illustrating her need to be reassured of her hypochondriac fears by one or more (s).
When the director of the nursery comes to complain to the psychologist about the invasion of the mother, it is, in our opinion, precisely the hypochondriac fears of the mother that were invasive, because insufficiently contained by the mother herself, for the director as for the whole of the crèche team.
Finally, with regard to the case of Octave's mother and Olivia, we question the - ordinary - need for *hypochondriac carrying*. Carrying is a guarantee of life: carrying the hypochondria of a future mother so that she can carry the embryo and then the developing fetus in her body until the end of the pregnancy.

The transnosographic complexity of hypochondria

The proposition that hypochondria is *transnosographic* (Aisenstein, Fine, Pragier, 1995; Fine, 2002, p. 802-803; Baudin, 2005, p. 61) is quite complex and difficult to grasp. Hypochondria covers a very wide psycho(patho)logical field and, ultimately, little thought in this direction. Hypochondria is often reduced to a more specific sense of the term, structural, psychiatric (Jean-Dit-Pannel, 2015; 2017; Jean-Dit-Pannel, Cupa, Riazuelo, 2018).
Aisenstein and Gibeault (1990) suppose "a minimum hypochondriac investment of the body necessary in any psychic organization" which "would be correlative of the investment of the object, and in particular the mother, of the bodily discomfort and pain during first experiences of satisfaction” (p. 34).
These propositions raise the question of a *primary hypochondriac maternal preoccupation*.

Within the mother-child bond (Winnicott, 1948; Aisenstein, 1990; 1991; Fédida, 2002; Szwec, 2002; Stathopoulos, 2012ab, 2015, 2017; Jean-Dit-Pannel, 2015, 2017, 2018), of the triad father-mother-baby and the *family body* (Cuynet, 1994; 1998; 2005; 2010; Loncan, 2015), there is an "ordinary" hypochondriac concern.
It is because the (becoming) mother and father (Missonnier, 2017a) seek to be *good enough* (Winnicott, 1948) that they become *enough hypochondriacs*. True "bodyguards" of their child (Missonnier, 2017b), parents become *enough concerned about the bodily health of their embryo*, *fetus, baby and then child*. "At the crossroads of the self-preservation drive and the sexual drive" (Stathopoulous, 2015, p. 563), parents' hypochondria about their baby(s) creates genuine *hypochondriac attention*, quite healthy, fundamental and bearer of life.
Maintained by and for a *family group*, this hypochondriac attention is inherited, transmitted by generational, *inter-* (which can be said between generations) and trans- (what is transmitted between generations *within words*) (Granjon, 2005 , p. 152-153) (for example inter- and trans-generational trauma, somatic diseases, in particular genetic and hereditary somatic diseases (Jean-Dit-Pannel, 2015).
It is our interest in the baby, in a psychoanalytic and psychosomatician vision (Bénony, Golse, 2003; Debray, Belot, 2008), supported by our practice with the baby and his family (Mellier, 2004; 2005; Mellier, Delion, Missonnier, 2015; Jean-Dit-Pannel, Delfini, Sarrey, Michel, Nachin, 2015; Jean-Dit-Pannel, 2019), as well as our research on hypochondria (Jean-Dit-Pannel, 2015; 2017; 2018), which led us to think of a *primary hypochondriac maternal preoccupation*.
We have retained the proposition of Ciccone (2012, p. 426-427; 2016, p. 20), according to which it would be preferable to evoke a *primary parental preoccupation,* rather than a *primary maternal preoccupation*, because "the primary preoccupation for a baby is not more maternal than paternal". In this article, we thus propose a *primary hypochondriac parental preoccupation* as a component of the *primary parental preoccupation*.
The members of a group of caregivers, here in a crèche, can offer *a reception and a treatment of the hypochondriac preoccupations of the parents*, by their *primary caring preoccupation* (Ciccone, 2012; 2016), and especially by one of its components which 'is, in our view, their primary hypochondriac caregiving preoccupation. Let us recall here on this subject that for Winnicott (1948, p. 84), a pediatrician before becoming a psychoanalyst, his consultations were, according to him, "a real treatment center for maternal hypochondria". In a crèche, requests for consultation of the parent(s) with a psychologist may be for prior hypochondriac treatment.

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