

Psychosomatic Aspects of Impending Premature Delivery

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Abstract: For seven years, the rate of premature births has remained at about one per cent in the practice of this gynaecologist and psychotherapist. Only two out of seven hundred births occurred before completion of 36 weeks of pregnancy. Assuming an essential influence of psychosomatic factors, the risk of premature birth seems to be enhanced by downward pressures on the foetus. Given the understanding and co-operation of pregnant mothers, supportive interventions aimed at resolving conflicts may result in conflict resolution and bring about a reduction of tension. Consequently there may be a marked improvement in gynaecologic findings and general health among pregnant mothers. Complementary medical intervention includes phytotherapeutic and homoeopathic medication, use of Arabin cerclage pessaries and surprisingly rare hospitalisation.

Zusammenfassung: *Psychosomatische Aspekte der drohenden Frühgeburt.* In einer gynäkologisch-psychotherapeutischen Praxis liegt die Frühgeburtenrate seit 7 Jahren bei ca. 1%, davon wurden nur 2 von 700 Kindern früher als in der 36. SSW geboren. Unter der Annahme des wesentlichen Einflusses psychosomatischer Faktoren scheinen bei der drohenden Frühgeburt (DF) die auf das Ungeborene nach unten wirkenden Kräfte verstärkt zu werden. Bei Einsicht der werdenden Mutter ist jedoch durch unterstützende, lösungs- und konfliktorientierte Interventionen möglich, daß bei Entspannung der Mutter und Lösung der Konflikte sich die geburtshilflichen Befunde und das Befinden der werdenden Mutter deutlich verbessern. Als ergänzende medizinische Maßnahmen kommen phytotherapeutische, homöopathische Medikamente, das Arabin-Cerclagepessar und erstaunlich selten stationäre Krankenhausbehandlung, zum Einsatz.

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An example to begin with:

A 32-year-old patient, a product manager by profession, was pregnant with her second child. In the 24th week of pregnancy, a routine examination revealed that her portio vaginalis had shortened to 1 cm in length. The anterior part was exerting slight pressure on the neck of the uterus. After intercourse, the patient had experienced light bleeding. The patient was informed of the findings and was advised to take things easy, to get some rest and to try to reduce external pressures. If possible, she should try to be aware of any dragging pain in the abdominal region or in the pelvic floor and to regard this as a sign that she needed more rest.

A week later, she came to see me again and said she wasn't feeling too bad. The cervix had further shortened and was now only 0.5 cm long, and pressure was still being exerted on the neck of the uterus. She was given a sick-note for a week, although it was difficult for her to be off work at that time, as her boss, the head of her department, was due to leave the company 2 weeks later.

Another week went by and she was exhausted, as her 2-year-old son had been ill and she herself had had a cold. However, she reported that her belly had not become hard anymore. The portio was still only 0.5 cm long, but all in all the belly was softer and extended up almost as far as the costal arch; the pressure on the neck of the uterus had eased off. The patient's sick-leave was extended.

Another week later, she said that she felt well and that her son had settled down; the findings on clinical examination remained the same, but the results of vaginal bacteriology were normal. I noticed that when she came up the stairs to my surgery (on the first floor) and after she had got dressed again after the examination, she was quite short of breath. I advised her to try to be more relaxed in going about her daily life and to try to start things as she was breathing out (in accordance with Marianne Fuchs' method of Functional Relaxation). I gave her a sick-note for a further 2 weeks.

At her next appointment, by which time she was 29 weeks pregnant, she was feeling well and said that she was trying not to get out of breath. She had even forgotten to put her watch on. The portio was now 1.5 cm long (!), and the anterior part was mobile over the pelvic inlet. It was decided that she should get used to going back to work gradually, and she was now able to work 3 hours a day. From this point onwards, she was in good to excellent health and form, and test results were good for the corresponding stage of pregnancy. We discussed at some length the problems she had had when her first child was born; she had very much disliked having a drip in her arm, and the baby had been born by forceps delivery after she had been given an epidural anaesthetic.

About 2 weeks ago, 3 days after the calculated date that the baby was due, she gave birth to a son in hospital spontaneously and without an oxytocin drip; the birth lasted only 31/2 hours.

I had already begun to become very interested in the subject of impending premature delivery during my clinical training. Surely, I thought, as in other illnesses that are difficult to treat, psychosomatic factors might play an important role. In the course of nearly 9 years of combined gynaecological and psychotherapeutic practice, I have had even more opportunity to develop a feeling for the underlying features and circumstances involved in this problem.

Basic Assumptions and Observations: Impending premature delivery should be regarded as an amalgam of physical and emotional processes. Pregnancy itself is, of course, not an illness, quite the contrary; but it is certainly a period during which considerable changes take place. Why, then, do disturbances occur?

The child is normally in a state of equilibrium between forces that support it and forces that push it downwards. Emotional tension can apparently result in the physical downward forces increasing, and the fetus is then pushed downwards.

Conversely, however, physical pressure can be transformed back into the emotional tension from which it originally arose. This frequently results in emotional suffering which is often considerable, but which can be worked through and resolved. At the end of the process, a new, more favourable state of equilibrium can thus be attained.

What are the clinical signs of impending premature delivery?

- Clinical findings. These will be familiar to the reader: changes in the portio and the neck of the uterus, contractions, etc.
- Symptoms. These include diverse types of dragging pain in the abdominal region, downward pressure, the belly becoming hard, the child moving downwards, and sometimes general fatigue and a feeling of exhaustion.

These are important signs and should be recognised as an indication of the need for the patient to change behavioural patterns for the better.

Interpreting symptoms as signs and understanding what they are indicating to the mother-to-be is, in my opinion, an important step in the right direction in therapy.

What else can be done? The obvious answer is to find various ways of relieving the strain on the mother-to-be: certifying that the patient is not fit for work; a longer break at lunchtime for the patient, if possible in bed; a home help, particularly for women who already have children; gradual re-integration into working life (a few hours a day) after sick-leave.

These measures relieve some of the strain on the patient, but more importantly they also give her more time for introspection and the opportunity to become aware of things and to change them.

How do tension and stress arise? Pregnant women obviously do not live in a vacuum; they have various external relationships and inner emotional realms. Tension can arise in all areas of these relationships, but also as a result of inner desires and fears; such tension can lead to a change in the equilibrium in the region of the cervix and uterus.

But the good news is that this tension, whether it be external or internal, can be resolved at exactly the same point as it arises. This is something the mother-to-be has to do herself.

Sometimes additional measures may prove necessary, e.g. medication, an arabin ring or occasionally hospitalisation.

Statistics: I see approximately 100 pregnant patients in my practice a year. In about 50 of these, signs of an immediate risk of premature delivery can be seen at least once during the course of pregnancy. Ten patients a year need an arabin ring. In the past 8 years, there have been approximately seven less serious premature deliveries among my patients in week 36 or 37 of pregnancy and four premature deliveries before week 36 of pregnancy. Two of these occurred during the first 3 years after I had begun to practice as a doctor, during which time the method was still being developed. Two occurred in recent years in the same patient; due to

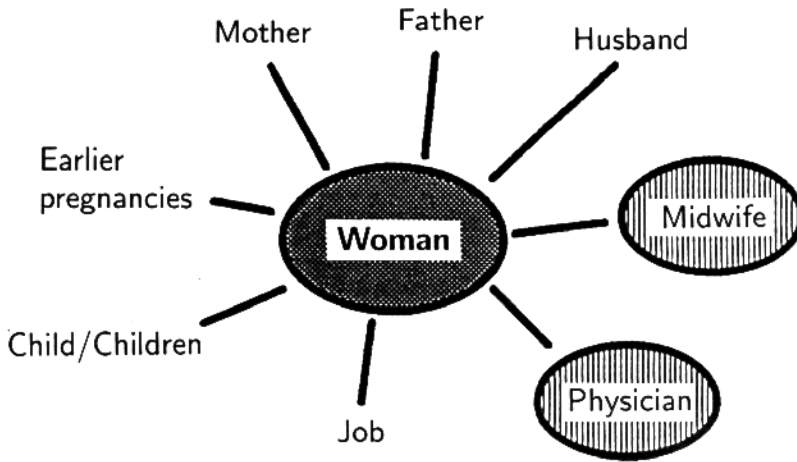


Abb. 1. External relationships.

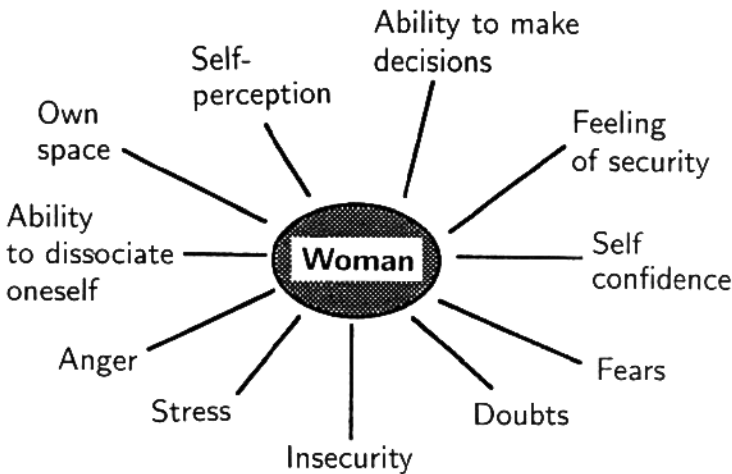


Abb. 2. Internal emotions.

communication problems (the patient was an Albanian asylum seeker), it was not possible to apply the method. Hospitalisation was necessary in two cases.

In order to illustrate the method, I would like to present a further example:

A 24-year-old educational science student came to me when she was 19 weeks pregnant. At the age of 3 years, after her brother was born, she was admitted to hospital to be treated for intestinal occlusion and underwent an appendectomy. She subsequently developed myocarditis and remained in hospital for 1 year for treatment.

When she was 17 weeks pregnant, she and her husband got divorced and she now shared a flat with her current partner and two other students. However, her relationship with the other two students was somewhat strained, and she and her partner were looking for a flat of their own.

In week 28 of pregnancy, the patient's belly often became hard; lying down did not alleviate the problem, and she felt the child moving more. The portio was reduced to nothing,

and the head was pressed against the pelvic inlet. Phase-contrast microscopy did not reveal any abnormalities. A size 3 arabin cerclage pessary was inserted.

One week later, the patient reported that she had been lying down almost all the time; the fundus was considerably higher, there was increased discharge, 1 cm of the portio jutted through the ring and the head was mobile at the pelvic inlet.

At week 31 of pregnancy, the patient felt better, 1.5 cm of the portio jutted through the ring and the head was above the pelvic inlet.

On the afternoon of the same day, she began to bleed (with the intensity of menstrual bleeding) and was admitted to hospital.

One week later she was discharged and took one tablet of Partusisten (fenoterol) three times a day. She had received a series of injections for lung maturation. When her mother had rung her in hospital, she had become worked up and had labour pains. When she was given the injections, too, she had also become worked up and had even stronger contractions. Then she had concentrated on herself and had calmed down.

To begin with, the baby was in the breech presentation, but this was able to be rectified externally. The patient spoke to her girl-friends a great deal.

Two days after the calculated date that the baby was due, the patient gave birth spontaneously to a baby girl weighing 3550 g.

More than a year later, the patient came to have a Pap smear. After her daughter had been born, she had lost about a stone and a half in weight (10 kg) and appeared to have changed considerably. When I asked her about this, she said that after she had almost given birth prematurely, she had overcome many of the problems in her life. She used to invest a great deal of energy in things as a distraction from herself. She had been caught up in the ideas and attitudes of her parents and had had difficulty in coping with situations of conflict. She thought that the ring might have become inflamed (thus causing the bleeding) because, although she had taken it easy physically, she was still emotionally fraught. In hospital, she had meditated a lot and had come to perceive a protective image from above, something that had helped her a great deal. Being overweight had been a form of protection, also against her parents, and it was something she no longer needed.

This patient managed to understand much about the impending premature delivery through her own insight and had been able to avert it.

I would very much like to see doctors and carers paying more attention to the psychological and social causes of impending premature delivery, and I hope that this paper has provided encouragement and stimulated ideas on this subject.