Int. J. Prenatal and Perinatal Psychology and Medicine Vol. 21 (2009) No. 1/2, pp. 55–62

Trans-generational Aspects of Psychosomatic-Psychotherapeutic Supportive Care during Pregnancy

Rupert Linder

Abstract: The contribution is based on a method that has been developed during practical work in an office for gynecology, obstetrics, and psychotherapy, which has resulted e.g. in an astoundingly low rate of premature births among the pregnant women cared for. It has been found that many physical problems in pregnancy should be regarded within the entirety of physical and emotional processes. In contrast to the traditional approach, symptoms are not regarded as problems that have to be got rid of, but are rather to be interpreted as signals and signposts that point towards more appropriate modes of behavior and lead to insights into the inner emotional history of the mother and previous burdens, arising from her own or her ancestors early history. This leads to suggestions for primary prevention, the encouragement of the expectant mother to improve her inner emotional and physical state and to get her unborn child free from mothers so far unconcious impairments. An overview about five different methodological levels within prenatal psychology and the importance of their inclusion into care of pregnancy is pointed out. This psychosomatic and psychotherapeutic work is a help to prevent pregnancy difficulties like repeated miscarriage, preeklampsia, HELLP-Syndrome, post partum mastitis and others. Three case histories are included.

Keywords: obstetrics, psychosomatics, methodological levels, psychodynamic psychotherapy, psychosomatic diseases of pregnancy, therapy, prevention

Introduction

In the following contribution, I would like to report about practical experience from my daily work which demonstrates how trans-generational aspects can profoundly influence the situation during pregnancy and birth. In doing so, I want to illustrate how the observation of methodological levels, which were dealt with during the ISPPM's conference in September 2007, can be helpful in prenatal psychology. This also holds for dealing with psychosomatically significant illness during pregnancy, about which I want to report more fully.

To make understanding easier, it is necessary to know something about the situation of my practice/surgery. First a few brief words about this. I have been practising in Birkenfeld, near Pforzheim, for 22 years and specialized in gynaecology and obstetrics as well as in psychosomatics and psychotherapy. I work on the basis of psychodynamic psychotherapy and I endeavour to fundamentally integrate these two sides in my daily work. Birkenfeld is a village with a population of 10,000, situated at the north of the Black Forest amidst woods with the small

river Enz flowing through the valley below. The town of Pforzheim is just next to it.

In the course of my psychotherapeutic training, I have gathered a lot of experience in single and group psychoanalysis. I have also concerned myself intensively with body psychotherapy, in particular with 'Funktionelle Entspannung' (functional relaxation, according to Marianne Fuchs). Of particular interest to me are solution-oriented, salutogenetic and system-oriented approaches.

Scientifically, I have worked principally with the psychosomatics and treatment of premature birth (cf. Linder 1997, 2006). Supportive maternity care and assisting at house births are further priorities in my work (cf. Linder 1994, 1996, 2005). My understanding of the trans-generational aspects of problems during pregnancy and birth was increased by the conference *Liebe, Schwangerschaft, Konflikt und Lösung – zur Psychodynamik des Schwangerschaftskonfliktes* ("Love, Pregnancy, Conflict and Solution – on the psychodynamics of conflict during pregnancy") which was held in Heidelberg in 2006 (cf. Linder 2008). This dealt with the deep-seated background sources of conflict during pregnancy, the survival of attempted abortion, ambivalence in contraception and the origins of these conflicts, which can make themselves felt over many generations. I wish to tell you about examples from my practical experience, of which none is simple, as is often the case in reality; somewhere between black and white, as life mostly is. It will become clear how important the extended prior history is in evaluating the problems in the current pregnancy situation. Here, the observations in gynaecological practice correspond exactly with those of bonding analysis. What bonding analysis observes on the inside, as it were, reveals itself to the gynaecologist on the outside with all the complexities of a real life situation.

Due to this complexity, the conclusions of the ISPPM conference in 2007 on *Methodological Levels in Prenatal Psychology* are helpful. The starting point was the need or requirement that it is necessary to analyse which levels we are dealing with in prenatal psychology and at which level we are working. The clarification of the methodological levels is important not only for working with pregnant women but also for working with infants or adults regardless of whether in the field of psychotherapy, medical situations, the work of midwives or other socio-therapeutic or socio-medical fields. It was important to identify these levels and to consider their significance. There are five of these levels:

1. The quantitative level
2. The qualitative level
3. The level of empathic insight
4. The level of practical knowledge of professional groups
5. The level of cultural psychological comparison.

In practice, it is of utmost importance for the unborn child's interests that the carers take into account and balance all five of these essential levels in their work in order to do justice to the reality of the child's life. The subsequent case histories will demonstrate how these levels are always present simultaneously and have to be newly balanced according to the situation. First, however, as background information I would like to identify the most important psychosomatic problem areas that the gynaecologist has to take into consideration.

Physical Illnesses during Pregnancy with Psychosomatic Aspects

In the following psychosomatic problem areas, psychological aspects play a greater or lesser role in each case. It is necessary to clarify these individually in order to gauge the possibilities of psychotherapeutic/psychosomatic treatment:

1. threatened miscarriage
2. status after recurrent miscarriage
3. morning sickness
4. premature contractions/premature birth
5. preeclampsia
6. HELLP-syndrome
7. "symphysial slackening", pelvic pains
8. breech presentation
9. dealing with overdue delivery
10. after birth: mastitis

In dealing with women after recurrent miscarriages, I thank Dr. Zeeb for the following literature extracts, which show that the chances of a woman carrying the child to term increase by more intensive accompaniment/supportive care from 30% to over 70%, (Stray-Pederson et al. 1984; Lidell et al. 1991; Clifford et al. 1997).

Premature contractions and threatened premature birth are of particular interest due to their importance in health politics as almost half of all perinatal complications and child deaths are due to premature birth. Consequent implementation of psychosomatic-psychotherapeutic possibilities of treatment, as outlined elsewhere (Linder 1997 und 2006), could be of great significance here.

Morning sickness, which is often difficult to access psychotherapeutically, is mostly alleviated by drip-feeding and supportive care.

The diagnostic consideration of preeclampsia and HELLP-syndrome as a psychosomatic illness is important because we are dealing here with really life-threatening illnesses for mother and child that can only be treated by emergency caesarean section. However, in my experience there are strong indications pointing to psychosomatic factors for which a therapy can be considered in advance of a new pregnancy.

Dealing psychosomatically with overdue birth is a delicate subject and requires the integral consideration of psychological and physical aspects.

The understanding of postpartum mastitis as a typical psychosomatic illness, resulting from the inability to cope with excessive psychological and physical demands, is now common to many obstetricians and midwives.

A new insight is the psychosomatic background to symphysial slackening or pain. Here, profound conflicts in the relationship between the pregnant woman and her mother, stemming from the embryonic and foetal stages, can play a role.

When ascertaining psychosomatic interrelations in gynaecological consultation, it is important to have a particular attitude which is open for every methodological level and in particular for the dimension of pre-verbal life. Here is a short explanation of this.

Perceptive Attitude in Gynaecological Practice

Prenatal psychology has taught us how important the early pre-speech stage is. Pre-verbal experience can express itself in dreams, emotions, moods, bodily sensations and feelings as well as in scenic realization. Here, I want to expressly include associations and re-stimulation. We know from the experience of Balint groups that the background of a problematic situation can reveal itself in the group. And it is exactly these aspects, which are sometimes seen as chaotic and perhaps hard to digest, that are of psychodynamic importance. They are therefore an important diagnostic instrument.

This can also be observed in the subsequent case histories. There aren't always instant right answers; some questions remain open. Sometimes it isn't possible to pigeonhole things. This is why openness, enduring not knowing and repeated appointments are so important. What might remain unclear in one session can be understood in a later one. What isn't possible in one session can happen of its own accord in a later one. Gynaecological action can only arise from an understanding of the whole situation based on the interactions of the relationships in consultation. Here the fundamental setting of gynaecological practice is analogous to free-floating attention in psychoanalysis, although there the patient brings into the session the totality of a concrete life situation in free association with different levels of their communications and behaviour, including bodily expressions. As a result of the great responsibility in understanding and taking action, a special intensity develops in the diagnostic and therapeutic situation. This exceeds the bounds of the normal psychotherapeutic situation and requires of the gynaecologist great presence and the permanent re-evaluation of experiences and perceptions.

Case-histories deal with ongoing therapies, as interconnections can then be more vividly and authentically described. I would like to point out that I have to present the complexity of the cases as they exist so that you can comprehend how it is eventually possible to distinguish the really important dynamically effective aspects which then facilitate sensible action.

This happens in a kind of circular process. When one particular aspect becomes comprehensible the therapist can then provide a stimulus relating to it, creating a new situation that facilitates new possibilities of understanding, and this in turn activates a further level. This process repeats itself several times. The whole thing has similarities with the mechanisms of a psychotherapeutic process, only all levels of reality are present. In addition, it could almost be said that the structure of this process is similar to the dialectic process described by Hegel with the progression from thesis to antithesis and then to synthesis, which in turn becomes the starting point for a new dialectic triple step.

Case Histories

Case history I – Denial of pregnancy in the prior history and its repercussions

Mrs A., in the second half of her twenties, lived together with her friend. She came to me in the 24th week of pregnancy with severe morning sickness requiring a certificate of illness. She was in her third year of nursing training. It soon became

obvious that she also had a drugs problem. She had smoked a lot of marihuana. In passing, she said that she had always had problems concluding things. This was a spontaneous statement, the significance of which would later become clear from her biography.

To begin with, I gave her a certificate of illness in order to take pressure off her. She wasn't able to give up smoking for the whole length of the pregnancy. We kept talking about it: sometimes it seemed as if she had managed to stop, then it was clear that she hadn't. Luckily, this point turned out to be not that important as the child was developing well. The ultrasound examinations never revealed any developmental deficits. I gave her an anamnesis questionnaire about her biography to fill in. These questions appeared on it:

1. Particularities during the pregnancy (your mother with you)?
2. How did the birth progress?
3. What about the months afterwards?
4. What do you know about your parents' relationship at the time?

The prior history of this patient is really special because on the questionnaire she described how she had been conceived. Her mother had had her first child at the age of 17. She was the second child, conceived during a chance encounter with a man at a summer festival 200 km away. Her mother had denied the existence of the pregnancy, although she had already had a child and must have been familiar with all the changes and the child's movements within her. Apparently, no one around her had noticed anything. There must have been some awareness somewhere, but it had quickly vanished. In the end, she went to hospital with suspected appendicitis. This was the birth of the woman who was now herself pregnant. Therefore, it was fitting that she said "I can't conclude things." I find this very logical in view of the mother's transference when seen from the trans-generational viewpoint.

Now, this is how it continued: unfortunately, she developed severe gestational diabetes. I am not depicting this from a theoretical viewpoint, but from the practical viewpoint as things developed in my practice where all the background elements of the different levels are always present and significant: the quantitative, qualitative, empathetic and the others. Mrs A. had in many respects, as could be expected from her prior history, a way of refusing to believe things. She visited the diabetes doctor irregularly – I worked together with an internist diabetologist. She also had difficulties keeping to agreements and missed appointments because "her mother or friend hadn't given her a lift." These are obviously the kind of things that frequently happen when there is a background problem with drugs. To begin with, she often didn't have the sheets with her daily blood sugar measurements with her. She gradually managed to improve measuring and bringing the results with her. For a long time, she was undecided if she wanted to have a house birth or not. But in the end, the diabetes and the necessity of intensive monitoring of the child made delivery in the clinic advisable.

The delivery date was one week overdue which, in the case of diabetes, required greatly increased attention and patience. However, the delivery went well and Mrs A. was really very happy and contented.

I have to add here that it wasn't possible for the patient to come to terms critically with her mother because she was too dependent in reality on her mother and her support. I did, however, keep bringing up the subject cautiously.

I hope it has become clear that the whole situation of the patient and the supportive care during pregnancy was overshadowed by the denial situation in the time before her birth. Knowing about this facilitated caring for her as well as possible under the given circumstances. Without this holistic approach, there was a danger that individual aspects could cause one-sided interventions which in their turn would cause a chain of further reactions which could have had severe consequences.

Case history II – Repercussions of being unwanted in the prior history

Mrs B. was 43 years old when she came under my treatment two years ago. The friend lived in another flat and she was newly pregnant. It was her second pregnancy. Her first child, a daughter, had been born 17 years earlier. She required prenatal diagnosis on account of her age. Due to anomalies in the region of the neck, I advised further clarification by standardised ultrasound screening with a colleague. He then calculated her risk factor. Going by age alone, this was 1:25 that the child had Morbus Down (Down's syndrome) and after the examination 1:15, i.e. even higher. We then discussed the matter, and after a detailed process of information she wanted no further diagnosis carried out. It was noticeable that she always had a radiant smile on her face when she believed in the intactness of her child. Parallel to this, there was a serious crisis with her partner that led to a separation. She had to go through a lot during the process. In relation to this, premature contractions set in, which, however, disappeared after the strain had been relieved by the discussions and temporary certification of illness.

She was always able to regain courage and bore the child normally. The collapse came 6 months after the birth. She then had a mental breakdown and I made an application for formal psychotherapy. In this context, it first became apparent to what extent the issue of being unwanted was important to her: she was the fourth child; the mother had got pregnant against her will by the child's alcoholic father. She kept arriving at the point where her feeling of security threatened to breakdown, which resulted in her feeling that she simply wasn't able to look after her child. She said she sat in her flat and could do nothing – regardless of whether the child cried or not. She had also started smoking heavily again and wasn't eating regularly so that she finally weighed less than 50 kilos. This depressive psychosomatic reaction had been triggered by the fact that the father of her child had promised her a certain sum of money and not kept to it. She felt that she was just hanging in mid-air. The non-appearance of the money had triggered her own prior history of being unwanted.

Another impression was that when she railed against the father in her distress, often the child was with her and it always screamed. We were then able to discuss this and she was able to understand it. Of course, she still has much to come to terms with and that can happen in the continuing psychotherapy.

Case history III – The effects of a lost twin in prior history

Mrs C. was 27 and had got pregnant unexpectedly. She hadn't expected it because she suffers from Crohn's disease and had had 20 operations on her abdomen and intestines – including an anal extirpation – and lived with a stoma. She came recently, in the 24th week of pregnancy, complaining of stomach pains and wanting a certificate of illness. This seemed to me to be a sensible way of relieving strain as she seemed to be overstressed and there was a suspicion of premature contractions despite her fundamentally marked commitment. The emotional and/or physical overtaxing of women is the most frequent cause of premature birth, and this is often underestimated. After two weeks everything had calmed down.

Her record revealed that she had previously suffered from pronounced neurodermatitis and it transpired that her mother had assumed she had had a miscarriage due to bleeding early in the pregnancy and thought the pregnancy was over. The mother had turned out to be wrong and in the end the patient had then been born. The situation of the lost twin and her own endangerment was discussed with her at length. She had made it but her twin had not. She was able to take in the interconnections. I think that the therapeutic efficacy of this work lies in the fact that people can talk about the traumas and share the feeling. So it was in this particular case and this is why I'm not really worried about the further progress of the pregnancy. She is now in the 34th week of pregnancy.

The question of the form of birth, i.e. how she is going to deliver the child is still unresolved. Her surgeon, in whom she has great confidence due to her years of illness, has voted for a caesarean section due to the scarring caused by the operations for Crohn's disease. My idea was rather this: the womb is the only undamaged organ so why subject it to this operation? I have now spoken to the chief physician of one of our gynaecological clinics – in this situation you're always the go-between – with whom it was possible to discuss the situation. He agreed with my opinion. It is, however, possible that the patient herself will want to have the caesarean section due to the traumatization of the many operations, in the assumption that her maltreated pelvic floor would be the better spared. There is to be further discussion here.

Concluding Remarks

An important observation in bonding analysis is that burdens in the prior history of the expectant mother and her mother are of far greater significance in the ongoing situation than is assumed in the normal view of maternity care, so confined to the present situation. This observation can be fully confirmed from the viewpoint of the psychotherapeutic-psychosomatic gynaecological practice, only here is even more complexity in the consequences of burdens from the patient's own prior history as well as the mother's, among others in the prevailing corporeality. It is evident that the early burdens shape the whole life situation of the expectant mother and the arrangement of her relationships. The awareness of the trans-generational depth of the prevailing situation makes it possible for the gynaecologist to take into consideration the different existential and methodological levels and so find a new balance between these levels. This is what makes possible holistic understanding of the patient's complex reality and so appropriate action.

References

Clifford K, Rai R, Regan L (1997) Future pregnancy outcome in unexplained recurrent first trimester miscarriage. Hum Reprod 12(2): 387–389

Lidell HS, Pattison NS, Zanderigo A (1991) Recurrent miscarriage – outcome after supportive care in early pregnancy. Aust N Z J Obstet Gynecol 31: 320–322

Linder R (ed) (1994) Haus- und Praxisgeburten. Mabuse-Verlag, Frankfurt

Linder R, Klarck S (eds) (1996) Hausgeburten, Praxisgeburten, Geburtshäuser, Entbindungsheime. Mabuse-Verlag, Frankfurt

Linder R (1997) Psychosoziale Belastung und Frühgeburt – Erfahrungen mit einem psychosomatischen Konzept in der Praxis. Arch. of Gynecology and Obstetrics 260(1–4): 71–78

Linder R (2005) Ermutigende Mutterschaftsvorsorge. Int J of Prenatal and Perinatal Psychology and Medicine 17(3/4): 247–252

Linder R (2006) How women can carry their unborn babies to term – The prevention of premature birth through psychosomatic methods. J Prenat Perinat Psychol Health 20: 293–304

Linder R (ed) (2008) Liebe, Schwangerschaft, Konflikt und Lösung – Erkundungen zur Psychodynamik des Schwangerschaftskonflikts Mattes, Heidelberg

Stray-Pederson B, Stray-Pedersen S (1984) Etiologic factors and subsequent reproductive performance in 195 couples with a prior history of habitual abortion. Am J Obstet Gynecol 148: 140–146

Correspondence to: Rupert Linder, M.D., Goethestr. 9, 75217 Birkenfeld, Germany, Telephone +497231-482223, Telefax +497231-472240, Internet www.dr-linder.de, E-Mail post@dr-linder.de