Klaus Evertz
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Rupert Linder *Editors*

Handbook of Prenatal and Perinatal Psychology

Integrating Research and Practice

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For our children and grandchildren

Preface

Prenatal psychology today can now look back on 100 years of theory and practice. In the beginning, it was the effort of a small number of people outside the psychological mainstream (Otto Rank, Gustav Hans Graber), who investigated the true origins of the individual's developmental history. Without a doubt, the individual human being emerges from within the emotional traditions of its parents and ancestors—and herein lie the origins of all psychology. The earliest experience of attachment is conceptional, then intrauterine, and later perinatal. Thus, earliest experience is the foundation for all later relations and attachments for all human beings.

This insight is relevant and useful in moments of crisis and, therefore, a topic for the practical application of prenatal psychology. It is also critical for the etiology of many somatic and psychic disorders. It is about time to compile this information in a compact book, accessible to the public as well as to all professions involved. It is time for a *Handbook of Prenatal and Perinatal Psychology*.

Its topics are of interest to many different specialized fields: obstetrics, child and adolescent psychotherapy, adult psychotherapy, psychology, social education, pedagogics, and others. The articles are intended to serve as a form of "introduction" and as a "foundation." Easy to read, and in accessible language, they bring together the essentials in the fields of history, research, obstetrics, neonatology, psychotherapy, prevention, and cultural psychology.

Prenatal psychology includes a great variety of approaches and methods. They reflect the spectrum of therapeutic efforts aimed at making the subtlety and fragility of earliest sensibility felt and once more accessible as a base for later behavior. Healing and bonding can thus become possible where before, vague fears and loneliness prevailed. It has been substantiated that the four known attachment types can be traced back as early as the prenatal realm where they are already established and formed.

The true potential of prenatal psychology is revealed in daily therapeutic practice as well as in the history of thought. The *Handbook of Prenatal and Perinatal Psychology* aims to contribute to the enhancement of individual psychology and to deepen the concept of man, as it will be needed for the future of a global human community.

The character of this handbook is special in a variety of ways. Usually, textbooks summarize the theoretic or practical knowledge of a specialized field or a field of practice once its central predicates have been validated and established. The field encompassing the prenatal period and birth, however,

needs to be validated, delineated, and answered for in an interdisciplinary way. That is why this handbook is of interdisciplinary character. It compiles findings and results from different scientific fields and fields of practice that—in other contexts—rarely communicate with each other. The common denominator for these different scientific fields and fields of practice lies in the live events of pregnancy and birth. In this handbook, they are (for the first time) jointly presented in a systematic manner. The backdrop for this joint presentation is a reflection of the different methodologic planes that characterize each of the separate fields from their differing perspectives, while they all have a relation to the psychologic aspects of pregnancy and birth in common. Each of these methodologic planes is delineated in their own chapter.

Important aspects include experiential research with regard to prenatal development, fetal programming, fetal stress, and epigenetics. Each of these aspects is presented in a separate chapter as well. Another field is the psychosomatics of pregnancy and obstetrics. Aspects of this field include ways of dealing with pregnancy and birth, the emergence of the earliest relationship between mother and child, the meaning of prenatal and preconceptional nutrition, avoiding risks during pregnancy by means of psychosomatic care, as well as the psychosomatics of life-threatening disorders such as preeclampsia and HELLP syndrome. The rapid development and extension of the physician-directed medical field of neonatology is a manifestation of the huge advancement of knowledge regarding the biopsychological processes during birth and the prenatal period. Knowledge in this field is a precondition for the support of premature children; and this became possible only a few decades ago. This is why we dedicate an entire chapter to this field.

The observations that occur during psychotherapeutic situations are particularly important to understanding the biographical significance of prenatal life and birth. These early experiences are preverbal; they require a particular, enhanced sensitivity and psychological intuition. A precondition to this historic development was great mental clarity and an inner independence from contemporary presuppositions and prejudices that deemed psychical experiencing to be impossible before birth. After the first fundamental cognitions by the psychoanalysts Otto Rank and Gustav Graber during the 1920s, the cognitive process evolved in rocky and eclectic ways; these are delineated in a chapter about the history of prenatal psychology. Today, there is a multifaceted prenatal-therapeutic scene that is presented in the introduction to the chapter about psychotherapy. This chapter addresses the prenatal dimension of child psychotherapy, baby psychotherapy, analytic and depth psychological psychotherapy, body therapy, katathym-imaginative therapy, and art therapy.

Questions regarding the empirical meaning of experiences during the first trimester of pregnancy present a particular challenge and are therefore presented in their own chapter. During its prenatal development, the child is exposed to more or less elementary experiences of shock on a scale that has been hitherto hardly known. These experiences may later provide the backdrop for seemingly irrational behavior as well as for somatic and psychic disorders. These correspondences are also presented in their own chapter.

One consequence can be drawn from the many-layered observations concerning the biographical significance of pregnancy and birth: primary prevention is crucial. There are different approaches; we present two examples: encouraging support for parenthood in an obstetric practice and the special support of the prenatal parent-child relationship in the framework of the support of the prenatal mother-child relationship—the so-called attachment analysis.

The final chapter of this book is called "Cultural Psychology." It looks at the fact that the prenatal period and birth do not only constitute meaning for the individual's life but also for collective experiences that are at the core of human concepts of the self and the world. The objective of this chapter is to create sensitivity toward this dimension of social and cultural figurations. These connections are very significant; we illustrate them with examples from the visual arts and movies. Individual and collective processing of early experience mutually explicates each other. This is also part of the reason why public reception of prenatal psychology is difficult. Individual history and collective history seem to proceed on completely different planes, while in reality, they are intertwined in the most intimate way. A psychology of the arts that includes the prenatal-psychological dimension can uncover these correlations. The way a society deals with pregnancy and birth shapes the mentality of its members. Vice versa, the mentality of a society has great influence on the way its children arrive in this world. Both aspects share a complex correlation. And prenatal psychology is a powerful means to understand and shape this correlation in a constructive way.

The interdisciplinary character of this handbook is reflected in the editors' different professional fields: Klaus Evertz is a painter, art and body therapist, and cultural scientist, Ludwig Janus is a psychotherapist and psychohistorian, and Rupert Linder is a gynecologist, obstetrician, and psychotherapist. This allows for a wide interdisciplinary spectrum—as it was realized in this textbook, and as it is required by the topic of prenatal psychology. The unifying connection between the editors is their qualification in prenatal and perinatal psychology, medicine, and cultural sciences, as it emerged from their respective professions, as well as their long-standing cooperation and connection of friendship.

Not least because of the novelty of its various aspects, and the particular complexity of interdisciplinary presentation, we consider this handbook as a beginning and an encouragement for further research and integration. We hope that the integrative compilation that is accomplished by this book is suited to facilitate greater public recognition of the inevitably interdisciplinary field of prenatal psychology. The aim is that the essential aspects of prenatal psychology are sufficiently taken into account within the different fields of practice.

Köln, Germany — Klaus Evertz
Dossenheim, Germany — Ludwig Janus
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We would like to thank the many pioneers in prenatal psychology, men and women, who had the strength to hold the line. Furthermore, we also thank our teachers and clients and all people who work on the idea of a rational and empathic humanity.

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About the Editors

Klaus Evertz works as psychotherapist and art and body therapist in his own office and at the Center for Palliative Medicine, University Hospital of Cologne. He is also a painter and a cultural psychologist. His research focuses on images as forms of consciousness. He also held lectureships at the University of Cologne, University of Dresden, and University for Art Therapy Nürtingen.

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Rupert Linder, M.D., is a gynecologist, obstetrician, and psychotherapist profoundly integrating these three specialties in private praxis. Dr. Linder directs research in prevention of premature birth and improvement of mother-child outcomes. He is past-president of the International Society for Prenatal and Perinatal Psychology and Medicine (ISPPM). He is intensely working on the integration of the medical and social realms of his area and supports programs for improving early mother-child interaction.

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Part I

Prenatal Psychology: Origins and Methodology

The History of Prenatal Psychology

Ludwig Janus

Introduction

The history of prenatal psychology began during the last century with the slow development of the insight that birth is not only an external event but also an elementary experience at an affective level which not infrequently could also be associated with traumatic aspects. These insights also broadened the horizons of empathy for the fact that our relation to the mother before birth, or our prenatal relationship, is, from the point of view of life history, the starting point for our later life experience. These insights are an expression of the expansion of our empathy for our history as a child, as a baby, and the preceding time. This expansion is the result of the historical development of modern mindset since the Enlightenment with its new possibilities of reflecting one's own experience and empathizing with the experience of others. In this way, the continued existence of our experiences as a toddler and as a pre-speech child has become accessible to us. It is precisely these experiences that form the core of our unconscious, and the history of prenatal psychology is a history of the awareness of these relationships.

In practice, this history begins with the publication of two books in the context of psychoanalysis in 1924, the "Trauma der Geburt" ("Trauma of Birth") by Otto Rank and "Die Ambivalenz des Kindes" ("The Ambivalence of the Child") by Gustav Hans Graber. Both books reflected for the first time the prenatal and perinatal origins of basal elements of our individuality. Rank writes that our coming into the world can be linked to elemental experiences of menace and survival, as well as loss and separation, which he summarized in the term "trauma of birth." Yet birth is not only a world gained but also a world lost, the loss of the prenatal world of life. This aspect was a priority for Graber, and he inferred from this the feelings of ambivalence toward the world.

Because we are born into the world so helpless and unready, we are on a lifelong search for a substitute that is initially found in the care of our parents, which offsets the deficiency by nurturing, warming, and carrying around. This compensation ensures our survival in the world. This need for protection later attaches itself to the father and the culture into which we are born. The prenatal root of the aspects of this need for protection reveals itself in that the father becomes the heavenly and cosmic Father, as described in our mythologies. This heavenly Father is intended to replace our lost womb world. And my society and my culture are equally my mystical home, which is why I devote my body and life to them. Here, it becomes clear that prenatal psychology deals not only with individual psychology but always with cultural psychology as well.

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The history of the discovery of the biographical significance of the pre-speech maternal experience in psychoanalysis took place in reverse. Freud first discovered the significance of the father as "paternal protection" for the childish experience and its mythological reflection, and only then did the early pre-speech maternal experience become accessible in the depth psychology of Jung and Adler. Here, Jung put the regenerative side of the early maternal experience in the foreground, while Adler made accessible the prenatal and postnatal menaces and traumas and the counterreaction of striving for power and security. However, this was only an initial approach, and it was not until the works of Rank and Graber that the significance of the early maternal experience for the life narrative became concrete.

Graber assumed here the positive nature of the experience of a prenatal self which is safe in the security of the "dual unity" with the mother. The abrupt nature of birth and its traumatic aspects rip the child out of this security and establish a fundamental ambivalence in relation to the world, which cannot replace this dual unity but forces deforming adaptations upon us so that birth is linked with a loss of self. In this sense, Graber's psychotherapy is concerned with making the experience of the prenatal self re-accessible and reestablishing one's own individuality in this experience (Reiter 2005). Similarly, Rank stated that the strengthening of self-experience in the "analytic situation" should enable the end of therapy to be associated with true independence and individuation with an enrichment of self-experience and a self-gain and not with forlornness and a loss of self as originally at birth (Rank 1926–1931).

The foregoing should make clear that the expansion of empathy into the prenatal time and the experience of birth, which has become possible through the development of modern mindset, has a paradigmatic character which requires a broader presentation (see the contribution of Ludwig Janus "Prenatal Dimension of Cultural Psychology" in this volume). The following presents an outline of the external history of prenatal psychology.

The History of Prenatal Psychology

A brief glimpse of the prenatal psychological perspective can be seen in some authors of the Enlightenment, as, for example, Johann Karl Wezel (1747–1819) who formulated: "It has been noted that not all, but most, currently inexplicable phenomena that are exhibited in many people to the astonishment of the learned and unlearned, would be very easy to explain if someone made known an exact and detailed story of their fate in the womb from the first moment of their existence until their birth" (quoted from Bennholdt-Thomsen and Guzzoni (1990), p. 117). In Adam Bernds' autobiography from 1738, prenatal-psychological connections have already been created in a very modern way when he writes: "... all of which (the fears of war) puts her (the mother) in great fear so that it comes as no surprise that he brought a melancholy disposition and a compressed heart into the world with him, whom the mother had carried nine months long under a heart worn with fear and anxiety, 'partus enim sequitor conditionem ventris'" (quoted from Bennholdt-Thomsen and Guzzoni (1990), p. 116).

This possibility of understanding, however, was forgotten in the nineteenth century which was dominated by the so-called scientific orientation so that actual prenatal psychology began in effect with the discoveries of Rank and Graber described above. Unfortunately, the recognition of their discoveries failed due to the continuing dominance of the scientific patriarchal zeitgeist. However, there was an underlying tradition of individual psychoanalysts who repeatedly reported on the updating of prenatal and perinatal experiences in their treatments (Janus 2000). Significant progress was made by the development of the traumatic aspects of prenatal life by the Hungarian analyst Nandor Fodor (1949). But the psychoanalytic societies were still so greatly influenced by the patriarchal zeitgeist that the prenatal psychological perspective could not gain wider scope within its framework. However, a gradually changing zeitgeist in the 1960s facilitated the founding in 1971 of the International Study Association for Prenatal Psychology

(ISPP) which developed into an interdisciplinary society for the study of the biographical significance of the pre-birth period and childbirth, leading to an expansion of the name to International Society for Prenatal and Perinatal Psychology and Medicine (ISPPM). The ISPPM was, and still is, the scientific forum for prenatal psychology and medicine in Europe through its congresses (see www.isppm.de) and the International Journal of Prenatal and Perinatal Psychology and Medicine (see www.mattes.de). A literature review of the most important papers on psychotherapy can be found in the anthology "Prenatal Psychology and Psychotherapy" (Janus 2004). The foundation of an interdisciplinary scientific society similar to the ISPPM was initiated in 1982 by the Canadian psychotherapist Thomas Verny and the Americans David Chamberlain, Barbara Findeisen, and William Emerson (American Association for Prenatal Perinatal Psychology and Health, APPPAH; see www.birthpsychology.com). In 1981, Verny made the public aware of the topic of experience before and during birth with his world bestseller The Secret Life of the Unborn Child.

Extensive observations in the psychotherapeutic situation led to the insight that a fundamental underlying condition for later mental illnesses lies in the immaturity of the parents and essentially unwanted pregnancy (Häsing and Janus 1994; Levend and Janus 2012; Hollweg 1998; Sonne 1996). It is not easy to broach this topic in psychotherapies, and this also applies to the therapists themselves; this, too, may be a significant reason for the problems of the acceptance of prenatal psychology in general psychotherapy. The assumption of the reality of prenatal development and the prenatal experience can often mean a devastating confrontation with one's own having been unwanted and endangered at a very elementary level.

Due to societal resistance, it was logical that further advances in the study of prenatal and perinatal experiences outside the established psychotherapeutic societies were carried out in humanist psychology. By using psychoactive substances such as LSD, it was possible to facilitate access to very early pre-speech layers of experience. In this way, Grof (1975) was able to recognize and describe the birth process with its phases of opening, expulsion, and passage in its continuity and in the symbolic and existential processing. In Germany, the Europäische Collegium für veränderte Bewusstseinszustände ("European Society for Altered States of Consciousness") initiated by Hanscarl Leuner (1981) was a forum for this research. The work "The Knowledge of the Womb" (1980); see also Janus (1991) from the Greek psychiatrist and psychotherapist Athanassios Kafkalides was groundbreaking for the recording of prenatal traumas. In England, Frank Lake (1980); see also House (1999), Ridgway and House (2006) was able to specify the consequences of prenatal and perinatal traumas. At the same time, developed his method of gaining access to traumatic prenatal and perinatal experiences by intensifying pre-speech feelings and bodily sensations, whereby during years of research, he also correlated the scientific evidence for the biographical reality of prenatal and perinatal experiences in detail with his observations (Janov 2012).

Building upon all these influences, the American primary therapist and prenatal psychologist William Emerson (2012; see also www.emersonbirthrx.com) was able, during years of work with regression experiences in groups, to develop maps of the prenatal mental development and phases of birth, the publication of which is expected in the near future. His work is currently being taught in Europe by one of his most important students, Karlton Terry (see the article by Karlton Terry "Pre- and Perinatal Baby Therapy" in this volume; see also www.karltonterry.com, www.ippe.com).

The body-therapeutic setting with its emphasis on sensations and feelings proved particularly suitable for facilitating access to the pre-speech level of prenatal and perinatal experience (Boadella 1998; Krens and Krens 2003; see the contribution by Bettina and Heiner Alberti "The Quality of an Original Experience of Being" in this volume.). It was possible to demonstrate the fundamental importance of a positive prenatal relationship and bonding experience for a later secure sense of self and relationship

(Krens 2001). These psychotherapeutic approaches are supported by the results of psychotraumatological research, which allow us to grasp the occurrences of traumatization and their processing much more accurately (Hochauf 2007; see also the contribution of Renate Hochauf "Analytical Psychotherapy and the Access to Early Trauma" in this volume; Unfried 1999). Stress research has confirmed the long-term effects of maternal stress (Huizink 2000; see the contribution of Bea Van den Bergh "Antenatal Maternal Anxiety and Stress" as well as the contribution of Thomas Verny "The Pre- and Perinatal Origins of Childhood and Adult Diseases and Personality Disorders" in this volume).

In general, it is now possible to integrate the different approaches as some recent publications have shown (Schindler 2012; Janus 2013; Renggli 2018; see also the introduction by Ludwig Janus to the chapter "Psychotherapy").

Quite independently of this, the realization is developing in medical-epidemiologic research that the prenatal milieu predetermines to a certain extent the basis of the physiological control of the organism. The extensive relevant research is summarized under the heading of "Fetal Programming" and has progressed so far today that empirical studies on these prenatal predeterminations are available for almost every significant area of disease. The titles of the fundamental works "The Fetal Matrix: Evolution, Development and Disease" (2004) and "Developmental Origins of Health and Disease" (2006) by the Australian/English epidemiologists Peter Gluckman and Mark Hanson express directly the claim of scientific explanation. In Germany, this new research was described in the book "Perinatal Programming. The State of the Art" edited by Andreas Plagemann (2011), in which the Dutch stress researcher Bea Van den Bergh in her article "Prenatal programming of cognition and emotion: From birth to age 20" forges a direct link between epidemiologic research and prenatal psychology. The basic neurophysiological processes in the prenatal predetermination of thinking, feeling, and behavior are described here.

Practical Consequences of the Development of Prenatal Psychology

The field of psychotherapy, which had been earlier divided into individual schools and methods, is becoming increasingly integrated. Empirical research, neurophysiology, and psychotraumatology are gaining the attention they deserve. The areas of encounter and cooperation are developing in the various depth psychology approaches, such as body psychotherapy, depth-psychological psychotherapy, and psychoanalysis. The new framework for this open field is "psychodynamic psychotherapy," where the prenatal psychological approach can also find its place.

This integrative and interdisciplinary approach was introduced to prenatal psychology in particular by the longtime president of the ISPPM, Peter Fedor-Freybergh (1987) and Fedor-Freybergh and Vogel (1989). This created a stable framework within which it was possible to combine the data from internal experience, developmental biology research, socialization research, psychotraumatology, and brain research. It is our responsibility to withstand the identity tension that results from such interdisciplinarity, whereby our practical competence as psychotherapists, obstetricians, midwives, cultural scientists, etc. is significantly enlarged (see the article by Ludwig Janus and Rupert Linder on "Methodological Levels" in this volume). Prenatal psychology has found a framework within this interdisciplinarity from which it can make its challenging observations and findings available to the other psychotherapeutic, medical, social-therapeutic, and cultural-scientific fields of science.

In practical terms, dedicated midwives, birthing assistants, and obstetricians have facilitated the change of mindset in recent years from a purely medical to a relationship-oriented support of pregnancy and birth (Klaus et al. 1993, 2000; Janus 1995, 2005a, b, among others). This also means that those working in the field of obstetrics and birth preparation are going to have to deal with the conditions of their own beginning of life. Today, midwives and psychotherapists have the

opportunity of acquiring prenatal and perinatal therapeutic competence through the continuing education programs of Karl Terry, William Emerson, Klaus Evertz, and Franz Renggli u. a. (see www.isppm.de).

A central consequence of the insights into the biographical significance of prenatal life and childbirth is the promotion of parental competence, as has begun in recent years, but which should be even more decisively implemented. The books by Verny (2003) and Hidas and Raffai (2006), among others, offer an orientation (see also the contributions by Gerhard Schroth, Jenö Raffai, and Karl Heinz Brisch in this volume). The promotion of parental competence (Armbruster 2006; Franz 2009; Janus 2006), especially in the lower third of society, has a much greater health-related political and sociopolitical significance than previously realized (Grille 2005). A possibility exists here for decisively promoting the capability of dealing with conflict, the capacity for peace, as well as a humane atmosphere in society. These qualities in human societies have hitherto been impaired by the prenatal, perinatal, and postnatal traumatic burdens prevailing in the early parent-child relationship, which were later enacted at the adult level in the wars and hardships of history up to the present day (DeMause 1996, 2000, 2005; Fuchs 2019).

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Methodological Levels

Rupert Linder and Ludwig Janus

Introduction

Several methodological levels usually have to be considered and balanced according to their respective significance. They have been named and developed during the past few years, also during special congresses of the International Society for Pre- and Perinatal Psychology and Medicine (ISPPM), for example, 2007, in Heidelberg.

Five methodological levels are important:

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

An approach including all these different levels is vital for sufficient dealing with pregnancy and birth, because therapeutic or preventive actions have to cover all aspects of the situation, particularly since the developing child does not yet have any direct means of codetermination.

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In a group discussion about *Problems of Monolinear Models*, each participant could cast three votes on the question as to what would be missing if there were restrictions at the methodological level.

At the *quantitative level* (1), the individual characteristics, the individual situation of each person, the emotions and the complex interweaving at many levels are not sufficiently allowed for. It would not be possible to represent adequately individual development, the certainty of a 'healing encounter', by reducing the complexity. Would the reduction at this level not be more of an expression of defence? The problem of conflict of interests in scientific studies (industry…)? The danger of one-sidedness, care when generalising? It is often necessary to have a period of 20–30 years to obtain significant results. In the end with some things, calculation is appropriate, with others' emotions.

The restriction to the *qualitative level* (2) would harbour the danger that physical collapse is not detected soon enough. This could go so far that one could call it loss of reality. There is also the question of how it is possible to draw universally relevant conclusions from individual experience. And the question remains of how language can access unconscious processes.

Statements based on empathetic insight (3) can be inaccurate due to false interpretation, problems of dissociation on the part of the ther-

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apists and their subjectivity. Their self-perception and self-awareness are essential in precisely this area. It might be difficult to differentiate between pre-speech memory and reconstruction in hindsight. A postnatal trauma could be concealed behind a 'prenatal and perinatal experience'. Myth creation could develop, especially with 'charismatic teachers'. Certain types of therapists can selectively attract certain types of clients, which harbours the danger of false generalisation. So it is also possible that one-sidedness can prevail at this level, every level of perception is necessary and the restriction to level three alone could also be of a defensive nature.

In *practical experience* (4), it is exactly the wealth of experience of the midwife's craft that should be considered. Important know-how can also be had from laymen. Fear and power are the two extremes that make this difficult to accept.

In *cultural psychological comparison* (5), literary reports from Africa were presented. Among others, trance was described as a culturally overlapping therapeutically effective procedure. It is, however, often the case that there is a cultural dependence on effectiveness. The subjective views and existential orientation of the dyad patient–therapist are of great significance. Knowledge from this area is of course not transferable on a one-to-one basis to another. Here also lies the danger of an incomplete observation.

In an *additional category,* the importance of intuition was highlighted, and the importance of introspection by therapists was emphasised. They have to be able to combine everything into a complete whole.

The analysis of the votes showed that one-sided restrictions at the methodological level hold dangerous problems and decisively limit the validity of the results. On the other hand, it is clear that there are no alternatives to integration and balancing of the methodological levels in theory and practice.

Practical Aspects of Methodological Levels in Obstetrics and Psychotherapy

The integrated use of obstetrical and psychotherapeutic measures enables the integrated use of the five methodological levels. In this connection, economic and legal factors are of additional importance. The special complexity of the gynaecological examination and treatment situations requires a permanent observation of the different methodological levels and their integration and balancing. In the process, one level can be of more importance at times, as, for example, the level of quantitative measurement when ascertaining obstetrical findings, the qualitative level when ascertaining personal and relationship characteristics, the empathic level when ascertaining the psychological dynamics of conflict, the practical level when including obstetrical know-how and the level of cultural comparison when dealing with members of another culture.

The obstetrical consultation situation, which includes a psychotherapeutic aspect, contains a unique complexity with which the doctor has to deal in the course of his therapeutic duties. It is exactly this conjunction of the objects of care, the pregnant woman, the unborn child and the expectant father that requires an integrative overall view of all three. This has, especially in impending morbidity, to include the environment as well as the subjective inner life and the previous history of those involved. In this relation, the self-awareness and self-reflection on the part of doctors and therapists are of great importance and of great relevance in particular for those clients with impending pathology. The systematic discussion of methodology should be continued in this area.

'How Can the Balance of Methodological Levels Be Maintained?'

There are again results from another *group discussion* on the topic *'How can the Balance of Methodological Levels be maintained?'*. The par-

ticipants or small groups, respectively, could cast their own votes. Important prerequisites for the necessary inquisitiveness and candour are here assurance, self-confidence and the dialogical inner exploration of therapists. New assessment and further development can develop from self-reflection. Profound self-awareness is a prerequisite for impartial empathy towards patients. The patient's biography can be understood in accordance with the dialogical principle. Access to the different levels can arise quite spontaneously in time the assurance increases and allows the possibility of conscious reflection. As special topics arose the question of how non-verbal communication can be documented and the ascertainment that gender-specific means of access are possible.

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' and pelvic pains
8. Breech presentation
9. Dealing with overdue delivery
10. After birth: mastitis

Perceptive Attitude in Gynaecological Practice

Prenatal psychology has taught us how important the early pre-speech stage is. Preverbal experience can express itself in dreams, emotions, moods, bodily sensations and feelings as well as in scenic realisation. Here, I want to expressly include associations and restimulation. 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 facili-

tates 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.

Now for the concrete 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 drug 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, and 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. *Pecularities during the pregnancy (of your mother with you)?*
2. *How did your 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 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 1 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 2 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; 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 2 weeks, everything had calmed down.