Pre- and Peri-Natal Psychology in a Developing Country

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Full Text: Headnote ABSTRACT: Psychology dates to the early part of the twentieth century in Yugoslavia, but developments in the science have been slow for a number of reasons. Lag in technological development and lack of financial support have been characteristic. Furthermore, sociocultural and economic differences between the regions have made an even development of pre- and perinatal psychological awareness impossible. There is now conflict between cultural values relative to pregnancy, the life of the fetus and abortion. Medical advances and social change have produced problems faster than they can be solved. The future role of pre- and perinatal psychology in solving these problems will be significant. Psychology as a science was born in Yugoslavia at the beginning of this century when the first experimental laboratory of psychology was founded at the University of Zagreb. From those early beginnings until today, the Zagreb school of psychology has mainly worked on an experimental basis, which naturally has had a considerable effect on the practice of psychology. Although in those early days our psychology kept pace with the developments in Europe and the United States, it later got out of step due to many different factors. One of the crucial factors was undoubtedly technological progress along with the country's financial resources which are a basic prerequisite for the development of any science. Since prenatal psychology is still a relatively new field of psychology, it is quite understandable why it has not yet reached its peak in Yugoslavia. Referring to the early beginnings of prenatal psychology in Yugoslavia, one cannot possible leave out the pioneering work of Professor Dr. Ivan Milakovic. Professor Milakovic made his first significant contribution in this field as early as 1967 when The International Journal of Psych-analysis published his article entitled "The hypothesis of a deglutitive (prenatal) stage in libidinal development." Since 1973 he has been member of ISSPM (International Society of Pre and Perinatal Psychology and Medicine), taking an active part in many medical gatherings and publishing an impressive number of articles and one book on prenatal psychology. Professor Milakovic is undoubtedly one of the key figures in this branch of psychology in Yugoslavia. There have been numerous attempts to form and establish societies of experts from various fields who showed a great interest in pre- and perinatal psychology and medicine, but they have all failed due to a number of reasons, mostly of a financial nature. Today, all those interested in this branch of psychology in Yugoslavia act individually, on their own, at the same time being members of international preand perinatal societies and other medical associations. Generally speaking, in a developing country such as Yugoslavia, where there exist great social and cultural differences, the prospects of developing prenatal psychology vary greatly with geographical and social space. Today, the differences are most conspicuous and apparent if we compare the northwest of the country, the Republic of Slovenia, where the standard of living comes closest to that of Western Europe, to the southeast of the country, the Republic of Serbia, where the situation is almost diametrically opposite. Such different standards have greatly affected not only the structure of population but also their way of life, forming different needs and different attitudes toward the modern practice of medicine and psychology. To illustrate this more clearly, here are some demographic data relating to Yugoslavia as a whole, and to each individual republic. The population of Yugoslavia today is slighly higher than 22 million. An average family has 3.62 members, but the differences existing between the republics are very great. Thus, the average in Slovenia amounts to a mere 3.18, whereas in the most underdeveloped part of Serbia it is as high as 6.92. While in Slovenia, the standard of living is high and birth rate markedly low (less than 1 child lper family), in the southeast of the country, the standard is low, and the birth rate considerably higher (4 children per family). One can also notice considerable differences between

birth rate and mortality in babies, which is of course closely related to the existing medical practice. For the sake of comparison, in 1960 the number of live-births per 1,000 inhabitants in Yugoslavia amounted to 23.5, natural increase in population was 13.6. There were 87.7 infant deaths per 1000 live-births, whereas the number of still-births per 100 live births was 1.0. In 1987, the number of live births fell to 15.3, increase in population was halved down to 6.2. The number of infant deaths per 1000 live-births was considerably lowered, amounting to mere 25.1, while the number of still-births was 6.6 per 100 live-births. If we study birth-rate and death-rate in individual parts of the country, we will again observe significant differences. For example, in Slovenia the number of live-births per 1000 inhabitants was 13.2, whereas in Kosovo, the most underdeveloped region of Yugoslavia, it was twice as high at 30.4. The same applies to the population rise, 10.2 compared to 24.8. Slovenia had 11.1 infant deaths per 1000 inhabitants, whereas in Kosovo it was 50.7. The number of still-births per 100 live-births was the same in both regions. The data coming from the other parts of Yugoslavia, highly correlated with the respective stage of development, are positioned between the two extreme ends of this continuum. The above data clearly show the diversities existing within the country, which seriously effect the existing medical practices. Or better to say, there is a strong interaction between medical practice and psychology on the one side and the standard and the way of life, on the other. One of the most acute problems in Yugoslavia is birth control and birth stimulation in view of the population increase. For example, in Croatia the number of births is almost equal to that of abortions, which means the birth-rate has been constantly falling in the last ten years, whereas the situation is entirely opposite in Kosovo, the most underdeveloped province of Serbia. It is quite logical that such a situation has a root in culture. On the one side, the inferior, unemancipated position of a woman, a very low level of education/learning and a strong influence of religion result in a high birth-rate. On the other side, the rapid and constant fall of the living standard in the developed parts of the country where emancipation and general education are at a much higher level has resulted in the decision not to have a baby. Naturally, a question is posed here: to what extent this decision is one made by a woman/a couple, and how much the community influences that decision. Since 1975 we have had a law on family planning which entitles everybody to free-will parenthood. In other words, every woman is given a legal right to end pregnancy within 12 weeks from conception, since in this time period the operative steps taken are easiest and safest. However, the fact that only 8% of the women who decide to end pregnancy in this way are adolescents gives grounds for anxiety. The rest are mature women who have been driven to abortion by reasons of social conditions. In some republics, where birth-rate has seriously fallen, the state has made attempts to stimulate birth of a larger number of children (for example, solving the family housing problems, tax benefits, etc.) but such steps will certainly not solve the problem as a whole, especially as they are not carried out throughout the country. In addition, there have been frequent protests lately in the form of stickers which are appearing in many public places, anathematizing the very thought of abortion, thus touching a very sensitive problem and accusing both the doctor and the woman of an alleged crime. These stickers give rise to a number of questions: Is the fetus a personality? Has the woman a right to make decisions? Whose responsibility is it to protect an unborn child? It is not my intention to give reasons for or against any of these attitudes or to find answers to any of the questions posed here, but to point out the important role which prenatal psychology and medicine could play in a society such as Yugoslavia, marked by numerous and multifarious changes. Both prenatal psychology and prenatal medicine open the doors to ideas hardly credible a short time ago. The society which aims at democracy tends to allow the presence of different attitudes and opinions but at the same time has to follow certain basic principles in order to maintain a kind of stability. Revealing the quality of the prenatal world and protecting the rights of the fetus, a question emerges as to the woman's rights. Where is the state to draw the borderline without making a mistake? The proximity of highly developed countries and the possibility of free communication make the information travel fast. But at the same time, a developing country, such as Yugoslavia, lacking in rapid technological development and economic power, is far too often flooded with new ideas and modern achievements without having time to absorb them. Sometimes these innovations

are accepted in very limited circles. This results in great discrepancies, frequent contradictions and in some cases the new ideas become a privilege of a limited group of people. This is precisely what is happening in the field of prenatal psychology. It needs popularization, public recognition and presentation of its benefits, and also broader association of prenatal psychologists with other experts. The rapid development of prenatal medicine calls for joining forces and acting together. A team of Zagreb doctors has achieved worldfamous results by the extensive application of ultra-sound in prenatal diagnostics and therapy. Their work and ideas are a giant step forward, but they also gave rise to a number of dilemmas and questions which are of great interest not only to medical experts but also to lawyers and psychologists. There seem to be many ways and open possibilities in which these top medical achievements could be misused or abused. The questions of ethics and morality are getting louder and louder. Owing to the dramatic development of science and medical technology which has made possible the use of techniques such as amniocentesis and ultra-sound, it is possible today to record a large number of fetal malformations (about 35) while still in uterus. A few of them may be treated prior to childbirth either indirectly through the mother's body or directly by treating the fetus itself. And this is where the cultural troubles start. What is justified, and what is not? Who is entitled to make a decision and give approval for a surgical intervention? Who is to be given the priority-the mother or the fetus? What to do and which steps to take if the mother refuses treatment, and the doctor believes there are indications to apply a certain therapy? A rapid development of fetal surgery makes such questions more and more acute. We are aware that some of the questions have not yet been given appropriate answers in any one country, but on the other hand, we also know that each answer has its specific cultural and social background. For example, in more than half of the states in the USA many regulations have been passed concerning medical research on the fetus either in utero or ex utero, whereas in Yugoslavia there are as yet hardly any such rules. The doctor acts in accordance with a generally accepted attitude that the autonomy of the pregnant woman should be respected. Thus, in order to carry out research and therapy on the fetus, the woman is the sole person deciding on the approval and cooperation. This also makes the woman the sole person entitled to make a mistake. The fact that many fetal disorders could not only be diagnosed but also treated prior to childbirth, the fact that we could now discover injuries in fetuses that will make their life out of uterus practically impossible, and the fact that fetal organs may be transplanted nowadays, proves the significance of prenatal medicine for humanity. However, in any prenatal medical intervention, no matter how simple it can be (even the visualization of fetus during the regular checkup of the pregnant woman), the knowledge of prenatal psychology is essential. In order to use all the benefits of modern technologies and new knowledge, medicine must have psychology's answers to some of the questions raised above. Here, special attention should be paid to the diadic relation of mother-child, and the triadic one of parents-child. Once more, it brings forth another typically Yugoslav problem: on the one side, we have operations performed on the fetus in utero (ultrasound examinations of pregnant women are part of the regular medical check-up) while, at the same time, father is not allowed to be present at childbirth and the baby is taken away from the mother immediately after childbirth. SUMMARY In conclusion we can say that Yugoslavia has all the prerequisites needed for an intensive development and practical application of the new ideas of prenatal psychology. The advance in prenatal medicine on the one hand and the existing social crisis on the other constitute a very specific framework for the activity of prenatal psychologists. At the moment there seems to be a split in the ideas and knowledge of medicine and psychology, and in their implementation. In order to use their potentials to the full, it is essential to apply the principles of reciprocity, of give and take, of mutual corrections and improvements. And most important of all-it is necessary to publicize the new ideas, to stress the significance of prenatal psychology and make it popular in the public domain. Make it acceptable. Make it interesting to others. Up until now, very little has been done in this respect. After all, what is the use of a science if its values/achievements remain behind firmly closed doors? AuthorAffiliation Melita Kovacevic, M.S.
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