How Women Can Carry Their Unborn Babies to Term - The Prevention of Premature Birth Through Psychosomatic Methods

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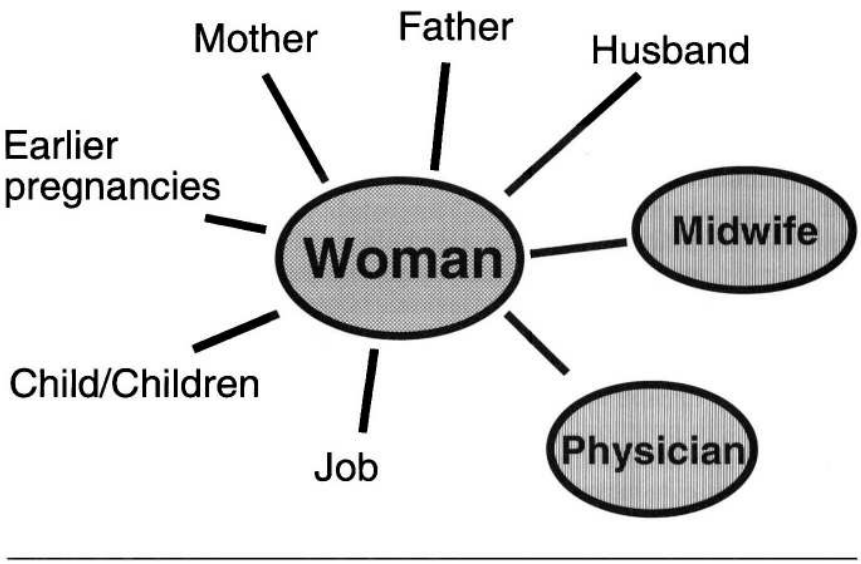
Full Text: Headnote ABSTRACT: This article presents a method that has been developed in Germany, during practical work in an office for gynecology, obstetrics, and psychotherapy, which has resulted in an astoundingly low rate of premature births among the pregnant women cared for. The actual rate of premature births in the last 15 years stands at something over 1 per cent instead of about 7 per cent usual in Germany. It has been found that a threatened premature birth should be regarded within the entirety of physical and emotional processes. In contrast to the traditional approach, symptoms are not to be regarded as problems that have to be got rid of, but are rather to be interpreted as important signals and signposts that point towards more appropriate modes of behavior. Suggestions for primary prevention are the encouragement of the expectant mother to heed her inner emotional and physical state and to get into contact to her unborn child. Four case histories are included. KEY WORDS: Prevention of premature birth, Prenatal care. INTRODUCTION In the course of almost 20 years of practical experience as a doctor specializing in gynaecology, obstetrics, and psychotherapy, a method has been developed which has resulted in an astoundingly low rate of premature births among the pregnant women cared for in my office. The conventional methods used in Germany to prevent premature births have so far achieved little success. The premature birth rate has remained virtually unchanged for the past 20 years at 7 percent. Already during my clinical training it was not unusual to be confronted with an threatened premature birth. Various conversations with the pregnant patients produced the impression that psychosomatic factors can play an important role in this problem. It was already immediately clear that the clinical findings are reversible under favourable circumstances. In practice, the understanding of the interactions between social situation, family circumstances, stress, and frame of mind resulted in considerable improvement in the tendency towards threatened premature birth. A high level of personal continuity throughout the supervision of the entire pregnancy coupled with the readiness to find time to consider subjective elements have proven beneficial. The observation that the reversibility of changes in the cervix and premature contractions occur parallel to changes in emotional and social conditions strengthened the impression that an threatened premature birth can be brought about by mainly psychosocial influences and is, therefore, treatable in the same way. BASIC ASSUMPTIONS AND OBSERVATIONS A threatened premature birth should be regarded within the entirety of physical and emotional processes. At the same time, pregnancy in itself is naturally not an illness - rather the contrary, but it is a period of great changes. These changes affect the bodies and emotions of the woman involved, her partner and their relationship, the rest of the family situation, and the entire social environment. The child is in a state of equilibrium between forces that hold it up and forces that press it down. Internal tensions appear to be able to increase the forces that push down. It appears that an increased basic tone as well as rythmic contractions play a role. In the course of psychotherapeutic accompaniment it is possible to achieve physical relief. Occasionally there can be a temporary increase in emotional suffering. This, however, can be worked on and, in time, dispersed. At the end of this process one may achieve a new and more favourable equilibrium. The number of premature births which in fact occurred fell drastically parallel to the development of this treatment concept, although approximately half of the circa 80 patients treated annually in the office showed a tendency to premature birth. None-the-less, the actual rate of premature births in the last 15 years stands at something over 1 per cent. Hospitalization was necessary in five cases. PSYCHOSOMATIC METHODS OF PREVENTING PREMATURE BIRTHS In order to

demonstrate the method, the course of action in the secondary prevention will be dealt with first, i.e. during pregnancies that already display symptoms or signs of premature birth. These signs and symptoms include: alterations in the cervix (palpable, or recognizable by ultrasound), contractions etc., various aches and pains in the abdomen, a feeling of downward pressure, hardening of the abdomen, child movements 'down', sometimes also general tiredness and lack of energy. In contrast to the traditional approach, symptoms are not to be regarded as problems that have to be got rid of but are rather to be interpreted as important signals and signposts that point towards more appropriate modes of behaviour. (Competent continual assessment of clinical findings is naturally essential.) The interpretation of complaints/symptoms as signals and understanding what they have to say to the pregnant woman is an important part of the therapy. In this respect, it is prognostically favourable when pregnant women who tend to suffer from contractions take heed of the contractions and are able to draw conclusions themselves as to which physical or emotional over-exertion they follow, which frame of mind is bad for them or which circumstances are good or not so good for them. A further step in advance of treatment is required for those pregnant women whose tendency to premature birth only comes to light through deteriorating obstetrical findings (which is seldom the case). First of all the bodily processes which led to the deterioration, and were incorrectly interpreted as child movements, sciatical complaints, or pelvic pains, have to be perceived for what they are. Experience shows that there is usually sufficient time to achieve this change as several weeks elapse between the first signs of a discernible shortening of the ectocervix and an imminent opening of the mouth of the uterus and this time can be used for psychosomatic and psychosocial treatment. It is therefore neccessary to ensure that regular and conscientious compilation of obstetrical findings takes place. What Else can be Done? Relief in varying forms: issuing a notification of sickness, having a longer after-lunch rest, if possible in bed, providing a home help - especially in the case of multiparous women. After total inability to work, a phased reintegration for a few hours into the working environment may be attempted. These measures not only provide the pregnant women with needed care but also give them the opportunity to listen into themselves, to observe more closely at the processes taking place within them and, if necessary, to change them.

Figure 1

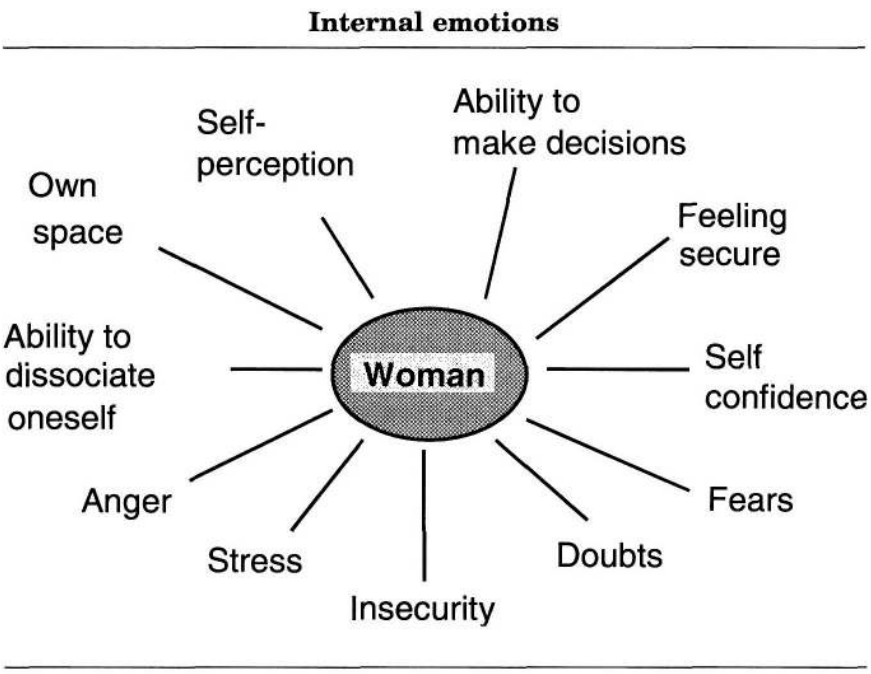
External relationships



Where do Tension and Stress Originate? Obviously pregnant women do not exist in a vacuum but are involved in various external relationships (Figure 1) as well as internal emotions (Figure 2). All of these external relationships, as well as the influence of internal hopes and fears, can be the cause of tensions which can produce a disturbance in the equilibrium of the cervix. Fortunately wherever the tension arises it can also be

removed at this same source, whether it is of external or internal origin. This cannot be done for the pregnant woman, but suggestions, the improvement of internal perception, and support in searching for possible therapeutic solutions are important means of help.

Figure 2



CASE HISTORIES As an illustration of this treatment concept some case histories are given in the following texts. In the first example of the manageress, who in the end forgot her watch, the obstetrical findings are given in greater detail. Case 1 A thirty-two-year-old patient, a product mananageress, was pregnant with her second child. In the 24th week of pregnancy during a routine examination it was noticed that the ectocervix had shortened to one cm (the front of which was pressing gently on the cervix) and slight bleeding had occurred after coitus. In a consultation she was informed of the findings and advised to take things easier, to find peace, and to reduce external stress. She should also watch out for pains in her abdomen or in the pelvic area which were a signal for increased peace. A week later she returned; she felt so-so. The ectocervix had shortened even more to 0.5 cm with continuing pressure on the neck of the uterus. She was given a week's notification of sickness, although this was difficult to arrange as her direct boss and head of department was due to leave the firm two weeks later. The week after she was exhausted as her two-year-old son was ill and she herself had a cold. The abdomen was, however, not hard. The length of the ectocervix was still 0.5 cm although the abdomen had from basic muscle tone softened and extended almost to the ribcage and the pressure on the neck of the uterus had been reduced. Her sickness certificate was extended. After another week she felt better subjectively, her son was less demanding, and the physical findings were unchanged by normal vaginal bacteria. It was noticeable that she got considerably out of breath climbing up to the examination room, which is on the second floor and also while dressing after the examination. During the consultation I advised her to take things even more easily and also to try to start doing things during a breathing out phase (from the functional relaxation after Marianne Fuchs). Her notification of sickness was extended for a further two weeks. At the next appointment, she was by now in the 29th week of pregnancy, she was feeling much better, and trying not to get out of breath. She had even forgotten to put on her watch! On this occasion the ectocervix was 1.5 cm long, the childs head was moveable above the pelvic opening. In the course of a phased return to work she was able to now work for three hours a day. From this point on she felt fine to very well with clinical findings in accordance with the progress of the pregnancy. During a long conversation the problems of her first delivery were discussed. She had felt very irritated by the infusion needle in her arm and finally she had had a forceps delivery with peridural

anaesthesia. In the end she gave birth spontaneously in hospital three days after the calculated date in three and a half hours without induction. This case history demonstrates how psychosomatic intervention can bring about changes in social and interpersonal areas, which, as a result of self responsibility and self observation by the pregnant woman, can lead to improved equilibrium. In this case a deeper-seated biographical background did not make itself noticeable. The individual conversation strategy works from the prevailing situation and moods are captured to understand the deeper-seated emotions. Possible solutions are then developed and discussed whereby emotional resources can be mobilized. Case 2 A 37-year-old midwife had been in prenatal care since the 7th week of pregnancy. In the 13th week she reported that she had been suffering pains in the groin. At night she had nightmares about her first pregnancy eight years previously when she had been left by her then partner shortly before she gave birth to her first child. In the 18th week the contractions had increased considerably, the ectocervix was visibly shortened to 1 cm, it was soft and the uterine cervical canal was wide open. In the course of a lengthy conversation we discussed her present situation, in which the partnership was good, and we also touched on her previuos experiences which had obviously affected her more than she had realized (wanted to admit). Everything was more immediate in the repeated experience of pregnancy. She was professionally highly committed, and she didn't find it easy to allow herself the quiet reflection that she needed to come to terms with the experience. She received a sickness certifcate for two weeks, a prescription for Viburnum opulus D2 and an appointment in four days' time. As she had left the practice in tears, it was also evident that she was in an exceptional emotional situation and at a decisive point. I phoned her the next day to find out how she was. She was feeling considerably better. When regular check-up appointments are made, it is always understood that they only apply when there are no negative developments. In cases of severe complaints/pains or changes for the worse the patients should get in touch earlier. Four days later the obstetrical finding had improved markedly (ectocervix was less centred, somewhat longer and less under pressure and the upper edge of the uterus was higher). Only two days earlier she had experienced strong contractions. She had felt that she needed a break. She was given a notification of sickness for a further three weeks and got at home help for twelve hours a week. It is usually such committed women who neglect themselves and the demands of the pregnancy and a clear break in their working lives is sometimes needed to allow internal changes to take place. During my absence on holiday she consulted a midwife friend and a colleague of mine. Her condition and the obstetrical findings had improved considerably, the uterus was soft, the ectocervix had further lengthened and the leading part caused no pressure at all. A gradual integration at work, at first for three hours daily, was now possible. She called on the afternoon of her first day back at work to say that it was not possible for her to work because she had experienced contractions after one and a half hours. The senior doctor's remark that her problems couldn't have been that bad, as she had not been hospitalized, had upset her greatly. The demands of work (Do this and do that ... quickly) had been too much for her. The next day she told me that she had felt extremely drained the previous evening. She had been affected by things that had previously not bothered her. She had been deeply upset at having to undress 12 infants and leave them screaming in their beds because the senior doctor of the children's clinic only had one hour in which to examine all of them. The obstetrical findings showed a deterioration (ectocervix approximately 1 cm, somewhat centered, the childs head moveable). Then she told me something about her story: the rest had done her, as well as her family, good. She had enjoyed being looked after by her partner for the first time in the partnership although she had felt somewhat awkward at first. Then it had provided her with the feeling of security that she would not be abandoned, which lessened her fears, which had bordered on panic. There had always been stress in her own family's home. She was the fourth child of six, her father had been a minister of religion, and her mother had always a lot to do as a result of being the minister's wife. Her father had died at work twelve years previously, after he had started work too early after a serious illness - Things are often clearer during a pregnancy. In addition to the obvious factors contained in case 1 (social work environment and the personal inner attitude to temporal rythms) other biographical factors become clear in this case: the severe

disappointment in the partnership during an earlier pregnancy and the high demands on herself in her profession, which have their origins in her family background. Case 3 In the course of her second pregnancy the then 33-year-old patient, successful in an artistic profession, showed a tendency to premature birth. Despite physical rest it became necessary in the 29th week of pregnancy to insert an Arabin cerclage pessary. At the beginning of the 37th week the pessary was removed due to contractions and her daughter was born safely on the same day. Two years after this she reported that she had been abused by her father during her childhood. Even though the external situation had been improved by physical separation, the internal proccesses of getting over the experience had only just begun. She was considering what kind of therapy could be useful when, by her next appointment, she discovered she was again pregnant. Although as the pregnancy progressed more psychic openness was possible, the patient still reacted in this pregnancy with frequent contractions, several times clearly in connection with contacts of her family members with her father, which disturbed her very much. It also became necessary in the 30th week of pregnancy as the ectocervix had flattened to insert an Arabin pessary. After that the emotional situation, which was easier to make contact with than in the previous pregnacies, became much more stable. Of importance to her during this time was her mother's and, in particular, her husband's support. It was possible to remove the pessary at the end of the 36th week of pregnancy. On this occasion the birth did not take her immediately by surprise, the child being delivered normally at around the calculated date. As can be seen from this case history, serious biographical burdens can sometimes have an important pathogenic significance. Obviously being abused by one's own father naturally has a deep-seated emotional influence. Noteworthy here is the clear improvement in the psychological state in terms of the ability to engage in more open conversation and allowing the working out of wider emotional experiences. Also physically the pregnancy could progress, as a result, more "normally" and be enjoyed, despite the necessary somatic treatment. Such serious biographical episodes are, however, seldom to be found, even in women who have a tendency towards premature birth. From experience the proportion is about one third. In about two thirds of such cases it suffices to intervene as in the first two cases given, i.e. the expectant mothers attain better internal temporal rhythms and more balanced emotions through heightened self-awareness. The third case also demonstrates that when the discussion of deeper biographical or social causes is not possible, and further therapeutic measures are necessary (e.g. Cerclage-pessary or hospitalization), nevertheless emotional factors can be effective although not yet at that moment able to be discussed, or, alternately the emotional suffering that is preliminarily attached to the recognition of the problem is not yet able to be coped with by the psyche. The elements of the therapy are given here in the following summary (Figures 3 and 4). PRIMARY PREVENTION After these examples of the therapeutic treatment of threatened premature birth, here follow some suggestions for primary prevention, i.e. prophylaxis in the absence of obvious symptoms or deterioration in clinical findings. Important is the encouragement of the expectant mother to heed her inner emotional and physical state. Even slight disturbances can be signs that indicate the need for alterations in physical activity, inner tension or other behavioural patterns. It is also necessary to watch out for abdominal or backpains (similar to those earlier experienced before or during menstruation) or general exhaustion. When the expectant mother feels well, the pregnancy progresses more easily, satisfactorily, in better health and more enjoyably. In this respect, here is a final case:

Figure 3

Medical intervention

Reduction of strain
(notification of sickness, home-help, more bed rest)
Medication
(homeopathy, aroma therapy)
Arabin cerclage pessary (rarely)
Hospitalization (only very rarely)

Case 4 A 17-year-old girl came in the 9th week of pregnancy to a prenatal checkup. She was able to speak openly about her past history and emotional situation. She had taken the pill up to the 5th week of pregnancy. Seven months earlier she had suffered a miscarriage in the third month of pregnancy in a neighbouring hospital. At the time she had been much upset by a remark of the senior consultant to the effect that the miscarriage was not that dreadful as she was still so young, and she didn't need to make a fuss about it. (This is a good example of how important it can be to avoid making off-the-cuff remarks. Miscarriages affect women emotionally more than is generally assumed - but that's a different topic ...)

Figure 4

Psychotherapy

Relief from internal and external demands
Helping overcome/remove fears
Detecting internal or external tension
Re-orientation
Improvement of socio-psychosomatic balance

Without doubt her social situation was not easy. Her parents had got divorced when she was six years old. She had experienced a lot of stress with her father during the first pregnancy. He had been totally against the pregnancy in the first place as had also been his new partner. Her mother had been supportive of her daughter. The evening before the miscarriage she had run away from her father. She was now living in her own flat together with her partner. After having given up the hated apprenticeship as a gardener which she had begun to please her father, she was now unemployed. When the child arrives she would receive financial support from government sources. At the following examination five weeks later that she was very anxious about losing this child. She had stopped smoking but didn't know how to react when she was in the pub in the evening with friends who smoked. It appeared important, while looking for a solution to the problem, to reconcile both of her needs: that of leading a healthier way of life for herself and her child, and that of a young girl's desire for social contact. On the one hand it was discussed how to make it clear to those around her that she wanted to do without smoke-filled air. On the other hand it was possible to consider alternative strategies for meeting her peer

group (friends), such as meeting at different times, at different places or at her flat. The strengthening of her own ability to make decisions promised in the long term to be more effective than an undoubtedly correct but hectoring explanation about the dangers of tobacco smoke. During the pregnancy there had been the occasional slight emotional and physical trouble spots but hardly anything in the way of an threatened premature birth. CONCLUSION It is obvious that the inclusion of these subjective factors in prenatal care will present those responsible for prenatal care with new challenges. Important is that those responsible for pregnancy care are prepared to invest time and provide an open ear coupled with the will to learn from what the expectant mothers tell them. A completed course in psychotherapy is of great use, but not absolutely necessary. Balint groups can also increase competence, perhaps theme centered interaction or of course further training in prenatal psychology. Developments in the remuneration system for the treatment of outpatients (EBM) has not been helpful in the creation of an adequate sytem of care which encompasses emotional needs. Gynecologists are restricted in their capabilities by the narrow budgets allowed for treating the women in their care. This is bound to present an obstacle on the way towards a psychosomatic, and therefore effective, method of dealing with threatened premature births. Gynecological and psychotherapeutic specialists' associations should commit themselves to bringing about the correction of these problems. What are the Limitations? Crucial for a noticeable improvement in the psychosomatic symptoms of threatened premature birth appears to lie in, above all, the willingess of the pregnant women, as well as their carers, to take psychosocial/psychosomatic problems seriously. However pregnant women are more prepared to learn something about their health and to use the opportunity to develop emotionally. This increases the patient's sense of self-responsibility and improves the requirements for successfully mastering the next steps: birth, adapting oneself to the child, breast-feeding, alterations in the partnership. Sometimes additional therapy may prove necessary, e.g. use of Arabin cerclage pessaries, or, in rare cases, hospitalization. However it is also advisable under these circumstances to use psychosomatic methods. Psychosomatic work on threatened premature births which also encompasses the subjective view of expectant mothers may at first sight appear unusual. Those who involve themselves with it will be rewarded in many different ways: with more success in treatment and with interesting and varied learning experiences, which reveal the ever more obvious relationship between the emotions and the body. AuthorAffiliation Rupert Linder, MD AuthorAffiliation Rupert Linder MD, the current president of the International Society of Prenatal and Perinatal Psychology and Medicine (ISPPM), is a practicing gynecologist, obstetric doctor, and specialist in medical pschotherapy in Birkenfeld near Pforzheim, Germany. Dr. Linder has published research and papers on various aspects of psychosomatics m obstetrics since 1990; as well as the psychosomatics of the threat of premature birth, post- term births, obstetrics in non-hospital settings, and supportive antenatal care, with focus on psycho-oncological issues since 2002. He can be contacted via e-mail at post@ dr-linder.de or via regular mail at Goethestr 9, 75217 Birkenfeld, Germany.

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