

## **Conflicts in Pregnancy: Reports from a Gynecological and Psychotherapeutic Practice**

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**Abstract:** This article expands further upon the primary topic of this special issue of JOPPPAH: conflicted pregnancy. The author employs case studies to delineate the broad scope of issues that arise to create complications and conflicted feelings upon discovery of a pregnancy.

**Keywords:** pregnancy conflict, abortion, pregnancy counseling

Pregnancies result, hopefully for the main part, from love. When one considers the wider concept of Eros, which includes desire, its different facets become even clearer, as the following paragraph will demonstrate.

In two scenes from the first series of the ARD serial, “Turkish for Beginners,” the two youngsters Lena and Cem demonstrate impressively the inner chaos, as well as the feelings of happiness, that prevail where love is concerned:

Lena, the daughter of a psychotherapist and Cem, the son of a Turkish policeman, end up together in one household as a result of the love affair between their parents. In the course of time erotic tension builds up between them. Unexpectedly, they are standing together in the hall as she discovers that he is in love with her. At first she is shocked and swears at him, “You asshole!” slaps him and escapes into Cem’s room. You can see in her facial expression what she is feeling. She is caught between different tensions (‘I’m going to faint’) as she realizes that he desires her and she has been latently attracted to him for some time. She says: “Don’t look at me like that!—I can’t help it.” As they approach their first kiss she says: “Bloody Turk,” he says: “Dumb German,” before they both land on

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his bed. In a second scene, on the morning after, they are both lying on his bed contentedly relaxed.

Almost all of the questions that are dealt with in gynecological practices have to do with relationships: of the woman to herself and her body, to a partner or, to the coming generation. In these areas belong many different questions about the functions of the female body: the different phases of the monthly cycle, the changes at the beginning of sexual maturity (the development of the breasts, pubic hair, menstrual cycle, the strong psychic disturbances during this time ...), contraception or the reverse side of this, desire for a child or preparation for a pregnancy.

In gynecological consultation various dimensions of life are focused on: the situation in life of the woman with its opportunities and contradictions, the influence of the partner relationship, her life story, the family situation of the woman and her partner, her work situation, etc. These realities of life reveal themselves simultaneously at different levels: in what she relates (verbally and non-verbally, i.e., in words, in fluency, in sentence melody, in pitch, with open or forced voice, in the accompanying body movements and facial expression), in the psychosomatic dimension of her complaints, and in the overall state of her health. It is therefore necessary to take into consideration the overall situation at every level, that is, psychologically, socially, biographically, somatically, and biologically. In order to achieve an integrated starting point for work during consultation all these levels have to be considered, not selected or segmented but in total and all encompassing. This means that in order to describe this process in writing it is necessary to reproduce in concrete terms each overall situation as it became known to me. This requires the reader to really think about the individual case studies and to become emotionally involved with them in order to understand the often very dramatic reality of life and the multi-layered personal situations.

A further difficulty arises from the fact that in our patriarchal culture the reality of mother and child is often hardly considered and not given its due importance in public discourse. Therefore, behind a (supposedly) simple statement such as "the man doesn't want children" there exists a large and complex reality, which is not easy to set forth and understood. It may have to do with partner conflict, as in examples B or E that follow. There could be financial difficulties, the woman could appear to be unable to cope with the children or feel as in example D, it could be the existence of an individual or trauma problem in the man's case (also E), etc. Despite this complexity, which can only be partially grasped, extremely significant decisions have to be formulated and resolved, as the examples make clear. In this respect, the dimension of time is significant as it can be helpful in providing an impulse for taking needed steps. Sometimes women are

relieved when the first 12 weeks of pregnancy have passed because at that point they cannot choose to terminate the pregnancy without severe medical indication. The time factor is often crucial during pregnancy because of the deadlines that have to be met. Particularly short is the time frame for using the abortion pill which can only be used during the three weeks after the period is overdue.

### **Case Histories**

Using the following five examples, I would like to describe some of the wide spectrum of challenges that can present themselves. These are five very different personal situations in exceptional threshold circumstances. If you can become involved emotionally, which isn't easy due to the emotional density, you will more likely comprehend the diversity of social, emotional, relationship-related, and cross-generation facets.

#### **Case Study A**

Mrs. A, who works in a technical profession at the computer, first came to my practice at the end of her twenties, ten years ago. At the age of 16 she had undergone an abortion. Her mother and grandmother had both had breast cancer. "I reckon with having some kind of cancer in my life," she said during her first appointment.

Some years later she said, "I'd like an anonymous artificial insemination, as I don't have a partner." She had already been in contact with a gynecologist colleague and had been artificially inseminated four times, without however, having become pregnant.

One year later, this was her statement, "Something has happened in my private life, my partner also wants a child. How can I get pregnant?" She quickly learned to understand her bodily functions, including mucus production in the middle of her cycle. With this knowledge, she sensed her fertile days and two months later was pregnant. She suffered occasionally from circulatory trouble, saying, "I feel like my batteries are totally empty and I sleep 12 to 14 hours a day." An amniocentesis was carried out in the 16th week of pregnancy on grounds of age. In the course of the pregnancy, she had occasional problems with premature contractions. However, she was able to balance this by looking after herself when necessary and paying more attention to her body signals. At term a normal birth produced a healthy child.

Two years after this, she reported, "It's about time for a second child." One year later she was pregnant. During the ultrasound (US) examination, it turned out to be with non-identical twins. She was

extremely shocked. "I didn't want three children. I know from a friend, who lives several hundred kilometers away, how exhausting life with twins can be. My parents are both no longer alive and I have no support." She told my assistant that she was considering having one child adopted and had already been in touch with the youth welfare department. At her next appointment she also spoke to me about these considerations.

Two weeks later one of the fetuses showed some abnormality during the ultrasound. Did it want to die of its own accord? An amniocentesis showed that one child had a trisomy 21, the other was normal. Two weeks later the child with trisomy 21 was dead, the second child continued to develop normally. There was no desire for lengthy (more intensive) psychotherapy. There was an improvement of the emotional and social condition thanks to more support from the partner. Despite a lot of work (job, in addition the purchase and conversion of a house and finally moving) her pregnancy went well.

### **Case Study B**

Mrs. B, is in the second half of her twenties and from a near East European country. She has a three-year-old son who was given away a few weeks after birth to the parents of her partner in yet another country. She stated, "I want an abortion." On being asked about her situation in life, she revealed that her partner had left the decision to her. She stated, "Sometimes there are fights in the relationship about trifles." I suggested a partner dialogue.

Five days later she came alone and said, "It was foolish to think of that (an abortion)." All through the pregnancy, however, she seemed to be very serious and her face never showed the least trace of a smile. She suffered some of the time from nausea and was once off work sick due to an influenza infection. She felt the child's movements relatively early (17th week of pregnancy). In the 25th week of pregnancy she fetched her son and shortly after went for two weeks' holiday with her parents in her home country. She occasionally suffered from premature contractions, the ectocervix was at times markedly shortened with a crater formation revealed in ultrasound examination. Using Tokolytikum oil to relax the uterus musculature and with rest she carried the child in the end over the calculated date of birth. During this pregnancy she gained only 15 kilos (33.1 pounds) in weight. I dealt with the clinic registration, explaining by phone the particular circumstances to the senior physician responsible for the delivery room. One week before the birth she smiled tentatively for the first time and said, "I'm quite all right, I'm just waiting day by day."

The child was born normally 11 days after the calculated date and she breastfed for a long while.

### **Case Study C**

Mrs. C, a 33 year-old woman from a southern East European country had previously had four abortions. She has been living for a long time in Germany, speaks accent free German, and is extremely well-groomed if somewhat mask-like. Her dealings with contraception have always been contradictory, she had each time taken the pill for only a short time, and had given up quickly because she had forgotten to take it. She had been repeatedly informed about other methods of contraception and wanted “to think it over.” Once again she was pregnant and stated, “A child isn’t convenient now.” The consultation didn’t last very long.

A few years later she said spontaneously during a cancer check-up, “I prefer riding a motorbike to having children.”

### **Case Study D**

Mrs. D, a warm-hearted, emotionally receptive, and motherly-looking woman had two children, ages two and three. An intra-uterine pessary had been fitted elsewhere and was positioned deeper than was optimal, i.e., in a less effective position in the uterus. She was informed of this but didn’t want to have any adjustment made.

Six months later she came to my practice with her period three weeks overdue. She was very confused. She already had two children, she and her husband had just built a house and wanted to move in in four weeks’ time. She felt she was “not far away from the madhouse.” She was also thinking about if and how she would find a job later. The examination showed an enlarged uterus corresponding to the time elapsed and the ultrasound showed an amniotic sac with an intact embryo lying next to the spiral. She asked about the formalities of getting an abortion. She refused offers of further discussion.

Three weeks later she came again, one week after the abortion had been carried out. Physically she was healthy, mentally she was not. She had already known in the recovery room that it had been the wrong decision. (The physical findings were in order.) She could only think of the fact that it had been the wrong decision. She wanted to have another child soon. They would have managed after all. The objections seemed to her to have disappeared. When she saw children at friends’ or in the street it was very painful for her. She decided to have psychotherapeutic sessions in short-term therapy. A few weeks after, she said that some days it was

better but that she still thinks every day about having done the wrong thing, saying, “The head thinks but the heart doesn’t understand.” Her husband was also not very enthusiastic and thought that she was already unable to cope with the two children who were there and didn’t have enough time for him.

What was awful was that there were so many pregnant women around her and that she couldn’t talk about her abortion, it had to remain secret. “I feel so alone.” With regard to her husband’s attitude, when she found out about the pregnancy, he had said, “It’s inside you, I have no say in the matter.” On the evening before the operation she had thought, “If he said anything about it, I wouldn’t have it done.” After the operation he had said, “I thought you wouldn’t have had it done anyway.”

After the ultrasound in my practice she thought she would prefer to have the child. He said afterwards, “but we did talk about it.” It is easy to understand how they both “just missed each other” in this respect.

During the time after the abortion and in therapy she talked a lot with her husband about the difficulties in their communication. Both had made mistakes. Both had to take responsibility for that. She mentioned feelings of guilt in connection with the deaths of other family members. She had bought the figure of an angel before Christmas and put in the kitchen. She had in the meantime been able to talk to her mother about her third pregnancy.

The intervals between the therapy sessions got longer. One week before the calculated date of birth, which she expressly mentioned, she said she was going to return to work. She felt better and that she no longer needed therapy sessions.

### **Case Study E**

Mrs. E, in her early thirties, was already mother of two children, ages seven and five from a first marriage. My colleague diagnosed an early pregnancy. At the second examination in the 7th week of pregnancy, she reported she was suffering from stress and had, since the day before, had abdominal pains on the right side. Her partner had said, “Either me or the child.” The ultrasound examination showed two amniotic sacs. Three days later the partner came along to the session. He said accusingly that he was being neglected, “The lives of four people are being destroyed—mine, hers, and those of the children already here ... I don’t want more children. I dreamed of a holiday every year in peace and being spoiled. My job is very strenuous ...”

One week later she came alone. She had separated from her partner. He had accused her of getting pregnant intentionally and with twins at

that. A few days later I saw her myself. She was completely stressed; the day before she had had a total emotional meltdown. The father had insisted on termination. She had ditched him. He was an only child. One or two friends were standing by her. Her son wanted to support her, the daughter was inquisitive. The examination results were all normal, the ultrasound showed positive heart activity twice. I told her the story of a woman who had had her best experience of pregnancy in her third pregnancy despite separating from her husband, a lot of work, and other pressures. In the 22nd week of pregnancy she was under stress from the father. His parents had phoned to say they wanted to obtain a court order from the youth welfare department to make her undergo an amniotic fluid examination. She came herself from a large family, however her mother lived a few hundred kilometers away. As a result of abdominal pains paired with a relatively intact ectocervix, I prescribed a household help for four hours twice a week and Tokolytikum oil.

A week later she told me that this relief was doing her good. She had some time to herself, could occasionally read, and also read to the children. She had been able to give up smoking two days previously. A few weeks later, she told me her mother had had a miscarriage of twins at six months. Her mother and father had each had children from previous marriages. She had been very attached to her father, who had died when she was 17. She talked every day with the children in her womb and told them, "stay where you are." In the 29th week of pregnancy the findings deteriorated, in that her ectocervix had shortened and was more sensitive. It was debatable as to whether the insertion of an Arabin-Cerclage pessary was necessary. The stress became no less. Her own divorce (from the father of the first children) was imminent. There were very unpleasant altercations before a psychologist and the youth welfare department. It was unclear whether the son was going to move to his father. She found some support in (distant) relatives of the child's father. A certain amount of cautious contact with the father of the twins came about ("he brings mineral water, leaves the car on loan in front of the door ...").

She remained constantly in internal contact to the two children in her womb. There were further legal arguments about custody of the older child. Obstetrically the clinic was considering whether the breech presentation of the foremost child would make it necessary to perform a caesarean operation. I therefore contacted the senior physician responsible. The patient developed severe water retention and had difficulties dealing with everyday tasks with such a large abdomen (circumference 108 cm [42.5 inches]). Ultimately the first child moved into a cephalic presentation and she was able to give birth normally in the 36th week of pregnancy, both children weighing almost 2550 grams (4.96 lbs.).

They were both discharged from the children's clinic and went home two weeks after birth.

The relationship to the children's father became more stable in the course of time, even if she retained a degree of uncertainty due to the conflict during the pregnancy. They later moved into a house together and got married.

### Reflections on the Case Histories

These examples are representative of the spectrum of different situations. The diagnosis and with it the growing awareness of pregnancy touches the deepest conscious and unconscious attitudes and opinions of both adults. In the process, resources are mobilized and sometimes, however, also memories of one's own old, often prenatal, injuries. The experiences of previous generations can also be significant and unconsciously influential. Different facets, backgrounds, and possible solutions will be demonstrated in the following contributions.

In the first example (A) a woman, who had a somewhat troubled relationship to herself (she reckoned with getting cancer at some stage in life), had made various attempts to get pregnant through artificial insemination - without success. She finally had her first child when her situation in life had so changed that she got pregnant normally as the result of a love relationship and, with support, mastered all the phases of pregnancy well. In her second pregnancy she had unwanted twins and was shocked for so long and so deeply that she actually thought about giving one child for adoption. This measure seems very extreme and might be shocking to the reader. However, it probably reflects the attitude of her own parents to their unborn children. Finally one of the children, already recognized as chromosome damaged in a prenatal examination, gave up and died in the womb. The other twin went through the pregnancy, apart from this occurrence, normally. In her case it was always impressive how she managed to cope on her own energetically with every external circumstance. Her independence is very important to her. The relationship to her partner always has a large (safety) margin. She was expressly told of the necessity of making her younger son aware of the existence of his twin.

The second woman (B) appeared from the start to be inhibited, depressed, and not really at home in herself, her surroundings, and the country (Germany) in which she lived. So it was not surprising that she gave up her first child (no doubt under external pressure) shortly after birth to the parents of her partner and could maintain very little contact. Her decision to have this second child nonetheless enabled her to create a



new relationship to herself. She finds some security in the journey to her parents and her native country in this situation of a new pregnancy. At the same time she was able to decide to fetch her son to her. Nonetheless, her emotional state is depressed during the whole pregnancy. Not until its end, when all the interdisciplinary arrangements have been made for as uncomplicated a birth as possible and relationships have been established through the special efforts of all the caretakers is she able to smile for the first time.

Mrs. C keeps getting unintentionally pregnant. She has never managed to permanently solve the problem of contraception. It almost seems as if internal factors are responsible for always getting her into the situation of unintentional pregnancy. However, this point could not be directly touched upon but seems to lie deep in her unconscious. She is only able to deal with these painful factors by means of repeated abortions. This situation can perhaps be explained by the greater frequency of abortions that exists in her cultural environment. This can also include her family or forebears. Perhaps she herself as an unborn child had been threatened with thoughts of termination. Riding a motorbike could be interpreted as a confirmation of her own physical existence in the face of such a threat.

Mrs. D is aware that she runs the risk of getting pregnant. This also displays the high degree of ambivalence towards the child that cannot be born. She fluctuates between empathetic compassion and the great fear of not being able to cope with the demands. This is mirrored in the ambivalence towards her husband. She feels her husband expects too much from her. They both just fail to find each other like the king's children in the well-known Grimm's fairy tale. She is capable of expressing her manifold emotional anguish clearly and candidly in the subsequent psychotherapy. She concerns herself intensively with the question of death and the end. She finds room during the process of mourning for love and closeness to the child (figure of an angel on the kitchen shelf). Finally openness and opportunity help her to be able to discuss this difficult problem with her mother. By the calculated date of birth, of which she is consciously aware, she can bring the development to a certain end.

Mrs. E shows a highly complex situation at different levels. Once again the great burden of being pregnant with twins becomes obvious. Especially striking is the vehement reaction of the father, which indicates personal traumatic experiences probably at his prenatal level. In addition there is the fact of personal instability in and due to living in a multiple patchwork situation. There also exist major burdens from the personal family of origin. This made the effort of letting her find a safe bolster in the therapeutic situation all the more important. Such difficult

circumstances often demand intensive and interdisciplinary cooperation between many caregivers (practice staff members, gynecologist, therapist, clinic, advisory center, psychologist, lawyer ...). In this example and within this framework she was able to continually find resources (even in the distant relatives of the child's father). Mrs. E's good emotional ties to both her unborn children were decisive in this situation. Finally, such an example can show how narrow the line sometimes is between good, successful development in a healthy physical and psychological range, and severe, possibly life-threatening complications.

Here can be seen how important the emotional openness and solicitude of caregivers is when dealing with pregnant women, particularly in conflicted situations. This is required immediately and in sufficient measure. In situations such as those described in this case, this cannot be restricted to the mere measuring of apparently inconspicuous physical findings but has to include other facets of the qualitative condition of the pregnant woman, the development of her life history, and cultural and social background. The openness of the caregivers for the underlying unconscious facets of the woman concerned, as illustrated by the examples given above, can help support them in finding the best possible solution for themselves and perhaps the unborn children as well. It is precisely the time during pregnancy and after that, with relationship-oriented accompaniment as well as an increase in value of actual relationships, which affords great potential for development of the prospective parents at every level.

It becomes clear from the examples that the concrete fates of the women and their children reflect all the opportunities and contradictions of our time as well as from the time of our parents and grandparents.