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Studying the Early Relationships in Prenatal Life: A Methodological Choice

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Abstract

The authors describe how their research on prenatal life was born through the joint efforts of a group of psychoanalysts and gynecologists. They emphasize three aspects of their methodological choice in the study of the early relationships between mothers and their unborn children: 1) an interdisciplinary approach, i.e. organizing a research team of professionals who work and study together, continuously exchanging opinions and feelings on their clinical experiences in order to give life to a common language; 2) a psychoanalytical approach, where emphasis is put on the group paradigm as the key to the unconscious universe of prenatal life; 3) a longitudinal approach, i.e. studying the relationship between the mother and her unborn child at different periods during and after her pregnancy.

Zusammenfassung

Die Autoren beschreiben, wie ihre Erforschung des pränatalen Lebens aus den vereinten Anstrengungen einer Gruppe von Psychoanalytikern und Gynäkologen erwuchs. Sie heben drei Aspekte ihres methodischen Vorgehens beim Studium der frühen Beziehung zwischen Müttern und ihren ungeborenen Kindern hervor: 1) eine in-

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terdisziplinäre Vorgehensweise, die darauf beruht, daß ein interdisziplinär zusammengesetztes Team regelmäßig zusammenarbeitet und kontinuierlich Meinungen und Gefühle über ihre klinischen Erfahrungen austauscht, um eine gemeinsame Sprache zu entwickeln; 2) ein psychoanalytischer Ausgangspunkt, wobei die Betonung auf dem Gruppenparadigma als dem Schlüssel zum unbewußten Universum des pränatalen Lebens liegt; 3) ein Längsschnittansatz, also die Untersuchung zwischen Mutter und ihrem ungeborenen Kind zu verschiedenen Zeitpunkten während und nach der Schwangerschaft.

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Psychoanalysis does not ignore the complexity of the philosophical problem regarding the very possibility of knowing the object in itself. Within its clinical setting, however, psychoanalysis is based on the assumption that nothing is knowable without a relationship, without a personal experience. Here and now the problem of prenatal psychology comes to the fore: what kind of a relationship might we have when the object is hidden within another object or inside the subject itself? How could we describe this special relationship where the distance between subject and object is always too long, or too short?

The ambiguous and elusive character of the object of prenatal psychomedicine helps us understand how and why research in this field has been moving back and forth, from an extremely biological (objectifying) to an extremely psychological (subjective) approach.

"The fetus between biophysics and metaphysics" is the title of the section of the proceedings of a congress on psychosomatic obstetrics. It is a clear example of this extreme situation, of this dualistic reductionism which Fedor-Freybergh has correctly acknowledged as one of the major epistemological problems in the science of prenatal life. In our opinion, this dualistic reductionism is a defence mechanism against the uneasy (multipotential and undifferentiated) nature of the unborn child as a research object.

While the biological approach does not risk too much objectifying the unborn child, the psychological approach, which must take always into account the subjectivity of its research object, risks to fail completely. The researcher risks to project into the unborn child his own psychological conceptions.

Thus, the undifferentiated and multipotential nature of the research object itself requires the shaping of limits/boundaries, i.e. the construction of a psychoanalytical setting where the emotional experiences centered around the unborn child can become the object of affective experience and elaboration.

The Group Paradigm

From a biological perspective, conceiving is a collective phenomenon. Numberless spermatozoa crowd around a single ovum. It is true that only one male cell will be able to enter the ovum, however that single spermatozoon can get in thanks to the capacitation function acted by the powerful crowd of all the other male gametes.

From a psychological perspective, we find the same situation. The conception of a baby becomes possible (so that it can really materialize and take shape) only when a whole set of syntonic stimulations by a group of meaningful parental figures has psychologically "capacitated" the parental couple.

Our understanding of human conception as a collective phenomenon explains why we organized an interdisciplinary group (of psychoanalysts and gynecologists, but open to contributions by neonatologists, biologists, and anthropologists) as soon as we decided to do research in the field of prenatal life. It also explains why the group paradigm was our Ariadne's thread into the labyrinth of the unconscious dynamics we experienced with the mothers we studied and their unborn children.

The observation of prenatal life cannot be founded indeed on the diadic setting of the classic psychoanalytical relationship. The most recent results of psychoanalysis and applied psychoanalysis should be taken into account: from the concept of transgenerational fantasies (Lebovici, 1988) to the last group analytical and ethnopsychoanalytical discoveries (Fornari, 1981; Ancona, 1988; Nesci, 1991).

The Interdisciplinary Team

By now, our interdisciplinary team includes: a psychoanalyst, a group analyst, a gynecologist, and a resident in psychiatry. We also have the supervision of a child-psychoanalyst and the supervision of a senior psychoanalyst who is also a group-analyst.

Once or twice a week, two gynecologists from our Ob./Gyn. Institute join our team in order to select or discuss the cases. When a baby is born, whom we observed *in utero*, and there is some medical problem, we consult a neonatologist from the Institute of Pediatrics. Finally, if a baby will present any mental illness, during our follow-up, we can consult a child-psychiatrist (and child-psychoanalyst) from our Institute of Psychiatry and Psychology.

Our interdisciplinary team met many, many times, for almost a year, before beginning with the actual research work. During these meetings we studied and discussed together the literature on prenatal and perinatal psychology and medicine so that we could share a common experience and build a common language.

Thanks to this preliminary work, our gynecologist (who is the sonographer of our interdisciplinary team) knows (not in a superficial way) what a transference is, and we all know the basic notions of obstetrics and ultrasonography. In other words, we built together our interdisciplinary culture.

During this process, the members of our team had to suffer all the unavoidable emotional distress and institutional pressures which "wasting" so much time implied (in terms of money, career, and immediate gratification which could come from our already established professions). The painful working through of such experiences helped us to improve our capacity to hold the anxieties of the expectant women we would meet with, in our clinical work. Holding the destructive impact of the dynamics of the academic power, without losing our embryonic group identity, has been the initiating rite that everyone of us had to pass.

The Research Protocol

Our team studies only one new case every week. All the women we select come from the ward of Obstetrical Pathology. The first day the patient is interviewed by one of our psychiatrists. During the interview, our resident in psychiatry acts as an observer and records the whole session. A trans-generational clinical story is collected, which includes both, the pregnant woman's family and her partner's. Emphasis is put on all the mothers of the extended family group and on their pregnancies. The same evening, an ultrasound session takes place in the same room where the woman was interviewed. Her partner (if possible) and/or other relative invited by the woman, can attend the session. The expectant mother lays on a comfortable bed and can look at a supplementary screen, especially arranged for her. The sonographer does not make any biometrical measures (as the ward sonographers are responsible for them) but uses the ultrasound scanner to help the woman experiencing a positive encounter with her child. All the session is recorded. At the end, the team works through the emotional experience.

The next day, the woman shares with us her experience of the ultrasound session during a second interview. Then she has two projective tests: the Rorschach, and a modified version of the figure drawing test (Soifer, 1985). Also this session is recorded so that the whole experience of the case is analysed in the weekly meeting of our team where all date is discussed. Finally, we have a further weekly meeting which is totally devouted to discussing general clinical and theoretical issues.

If we add to all this work the supervision of our child-psychoanalyst, every two weeks, and the monthly meeting with the director of our program (the psychoanalyst/group-analyst) it is easy to understand how demanding our research schedule is. Actually every case is studied three times, during the course of pregnancy (first, second, and third trimester) and our immediate follow-up includes observation in the delivery room, in the nursery (while the mother is feeding her baby), and at home, periodically.

We think that our psychoanalytical approach, which implies establishing a relationship between an interdisciplinary team and the unborn baby, through a non superficial relationship with the mother and her extended family, is the best way to be able to reach, in the next thirty years (the limit we figured out in our follow-up) a preliminary nosography of the early relationships.

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agnosis not only for a conscious ignorance but also for an unconscious disavowal of his own emotional reactions to the patient's deepest anxieties. In this paper the authors report the transcripts of the ultrasound sessions with two pregnant women who suffered, in a previous pregnancy, the loss of a child. Both of them felt deep anxieties and projected them into their sonographers (transference) inducing wrong or poor diagnosis. Working as an interdisciplinary team of psychoanalysts and gynecologists allows to prevent such mistakes and work through, during the ultrasound session, the patient's anxieties.

Zusammenfassung

Der Ultraschalluntersucher hat eine doppelte Rolle: Bewertung der klinischen Situation einerseits und Funktion eines Hilfs-Ichs für den Patienten andererseits. In dieser zweiten Funktion wird der Ultraschalluntersucher zu einem Projektionsfeld für die unbewußten Ängste der Schwangeren, die dadurch einer Durcharbeitung zugänglich werden. Dies wird oft übersehen. Wenn der Ultraschalluntersucher sich selbst gegen die Ängste der Patientin durch Verleugnung, Verdrängung und/oder Verschiebung abschirmt, kann eine gefährliche Situation entstehen. Wenn die Ängste der Patientin sehr tiefsitzend sind, kann die professionelle Kompetenz des Ultraschalluntersuchers geschwächt werden und er riskiert, daß seine Interpretation des Ultraschallbildes die unbewußten Phantasien der Patientin spiegelt. Wenn der Untersucher seine eigene Gegenübertragung nicht beachtet, läuft er Gefahr, statt einer klinischen Interpretation das unbewußte der Patientin auszuagieren und wiederzugeben. Dies kann deshalb geschehen, weil der Ultraschalluntersucher aus dem Ultraschallbild den klinischen Befund aktiv konstruieren muß. Deshalb kann es immer einen Irrtum geben. Die Wahrscheinlichkeit hierfür ist umso größer, je weniger der Ultraschalluntersucher sich der Beeinflussung durch unbewußte Ängste der Patientin bewußt ist. Ein Wissen um diese Zusammenhänge sollte einen wesentlichen Aspekt seiner professionellen Kompetenz darstellen. Der Ultraschalluntersucher sollte wissen, daß er eine falsche Diagnose nicht nur wegen bewußter Unkenntnis geben kann sondern ebenso wegen einer emotionalen Beeinflußung durch unbewußte Ängste der Patientin. In diesem Artikel geben die Autoren die Transkripte von zwei Ultraschallsitzungen mit zwei schwangeren Frauen, die während einer früheren Schwangerschaft das Kind verloren hatten. Beide projezierten unbewußte Ängste auf den Ultraschalluntersucher und verursachten hierdurch eine falsche oder unvollständige Diagnosestellung. Die Zusammenarbeit in einem interdisziplinären Team von Psychoanalytikern und Geburtshelfern ermöglicht, solche Fehler zu vermeiden und der Patientin bei der Durcharbeitung von Ängsten während der Ultraschalluntersuchung zu helfen.