

# Model of Comprehensive Programme for Prenatal Care and Adjustment for Delivery

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**Abstract:** The proposed model of the comprehensive programme for prenatal care and adjustment for delivery takes in consideration an interdisciplinary approach when dealing with pregnancy. Psychological and social aspects are stressed and focused on the interaction between mother, father and the prenatal child is emphasized. Practical advice for both expecting parents and professionals is included.

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Comprehensive adjustment for the delivery is a part of a complex prenatal care. It consists of medical, psychological, social and cultural components. If the emphasis is not on the psychology of the mother, father and the prenatal child, the domination of the medical care overweighs and results in less comprehensive understanding of the child from conception, and also of the parents. The parents are thus often considered merely as the objects of somatic care. Little respect is paid to the psychosomatic and somatopsychological processes present in the course of pregnancy and delivery with little regard to the psychological needs of mother, child and father. Little account is paid to the WHO definition of health in its psychological and social dimensions.

Comprehensive prenatal care and adjustment for delivery contains a strong primary prevention, important for the optimal acceptance of the neonatal child by its mother and father. It plays a relevant role in the course of pregnancy and delivery in the further somatic and psychological health of child, mother and father.

If optimal prenatal care is lacking, the primary preventive potential neglected, and the approach exclusively biological, then the comprehensive health care loses

the adequate modern and interdisciplinary quality level, which the mother, child and father are justified to expect.

Optimal prenatal care requests team work, unifying midwives, nurses, physicians, psychologists, rehabilitation workers, therapists, social workers and others. Free space should be left for the spontaneous activities of mothers and fathers. The parents should be informed about their rights and duties, advised to take competent decisions chosen from different possibilities and helped with the dialogue with professionals.

The preparation for delivery as usually practised is of fluctuating quality and only exceptionally of a complex nature. Missing is the psychological adjustment and care, psychotherapy for indicated cases, the technique of breastfeeding etc. Even the elementary method is often abbreviated and not proposed to mothers until the last trimester or even during the last month of pregnancy. It is usually reduced to the basic information about the biology and physiology of the delivery, the hospital environment, sometimes completed by showing videos from deliveries.

To mothers with risk pregnancies not sufficient care and delivery preparation is offered although, it is just this group which should be specially guided and offered possibilities for psychotherapy.

Parents are seldom trained for mutual cooperation at the delivery, and fathers are often passive participants. Even the best intentioned education does not prepare mothers and fathers for natural delivery, but only for so called classical delivery.

Complex preparation for delivery contains also philosophical, cultural, anthropological and even religious aspects. The traditional so called classical delivery and the preparation for it is a kind of heritage from a hierarchic undemocratic society, and reflects a totalitarian state of mind where the woman in travail is completely submits to the authority of the physician and the authoritative medical system, adapts herself to it and submits to the power principle. The attitude of power position dominates, mostly unconsciously, the mind and praxis of the obstetricians and motivates their resistance towards the new ideas and practices, which are endangering the consequences by their power principle. This happens even when new attitudes are contradicted by the arguments of specialists, forming, in fact an alibi for resistance and even recognition of the new ideas.

The father represents the psychological and social stabilizer of the family and has a given place in the prenatal as well as the perinatal stage of care.

From the very conception on, the prenatal child is in immediate interaction with the biological and psychological process during the mother's pregnancy, in which the relationship between mother and father and the whole family is reflected.

The model of the complex programme for prenatal care arose from the integrated and holistic attitude towards the pre- and perinatal evolutionary stages of pregnancy and delivery, according to the new paradigm which exceeds the limits of the mechanistic, materialistic reductionism in medicine, as defined by P.G. Fedor-Freybergh (1981).

The complex programme accepts the WHO definition of health, qualifying it, not only negatively as the absence of illness, but also positively, as the state of the good somatic and psychic condition of life satisfaction and well-being.

We live in a democratic society, based on the principles of partnership, free choice and decision, and these principles should be reflected also in the prenatal care and delivery preparation.

The complex approaches towards the prenatal care and the adjustment for the delivery are accepting the results of the medical and psychological research and of the empirical experiences, leading thus to an integrated biological, psychological and social attitude.

In the work of psychologists the most important is the strengthening of the health and its positive part. Their assistance should not concern primarily therapy, but the application of strategies for primary prevention. Pregnancy offers the ideal possibility for such primary preventive intervention. It enables both the mother and the father to develop self confidence, minimalizes unnecessary stress and helps them to master a crisis situation, which pregnancy often represents.

In connection with the complex adjustment for delivery, we refer to the "locus of control", its internal or external localization (Auerbach et al. 1976; Lowery et al. 1975; Kotaskova et al. 1981) and the "healthy localization of the control" (Fellner et al. 1980) as well as the measure of competence (Adam 1981). The localization of control within the proper Ego means the capacity for taking over the greater or full competence and responsibility towards life, morality and health. The current practices of prenatal medical care and a biological oriented adjustment for delivery are in localizing the control outside the client, the mother, the child and the father, which leads to manipulation with the client as an object of medical care. During physiological delivery, the health worker accompanies and helps the mother. Through the pathologization of delivery, the mother's psychology, her experience and human subjectivity are not respected, and only the mechanism of delivery is concerned. The mother follows the orders of the obstetrician only, regardless of her own needs during the physiological childbearing process. In the case of true pathologic delivery, such an attitude is inevitable, but not in the physiological delivery, as represented by the overwhelming majority. In such cases the adjustment helps the mother to localize the control within herself, and give way to the spontaneous physiological process.

The importance of Miller's conception (Miller 1969) lies not only in its pragmatism – prevention being cheaper than therapy – but also in its ethical message. Both medicine and psychology should prevent pain, not only helping to bear it, but to alleviate it.

Health was defined by Fedor-Freybergh (1974) as "the dynamic movement along the creative path toward the self-realization", understanding not only in its physical or mental appearance, but in a complex way as a concept of the individual life quality. Health represents a creative equilibrium in the dynamic process of pre-, peri- and postnatal stages of life. Health becomes a part of human personality and its potential. Pregnancy and delivery are creative processes. In the complex adjustment for delivery we help the mother to use her creative potentials.

Prenatal care as well as the adjustment for delivery need highly developed medical and psychological individual care. To reach this goal it will be necessary:

1. to accept the necessity of psychological care by obstetricians;
2. to establish a proper postgraduate education for medical and paramedical personnel who will provide the complex care;

3. to supply mothers with qualified information about prenatal care through existing information sources e.g. media;
4. to change the legislative paradox in the Czech Republic according to which qualified medical and paramedical personnel, physicians, midwives, nurses, psychologists, birth educators etc. are not allowed to advertise, in any form, courses for prenatal care and delivery to mothers and fathers, while non professional individuals with business licenses are allowed to advertise such services without restraint and, what is even worse, without any expert control;
5. to include information, starting with elementary education, developing a complex social network on a broad basis.

Through optimizing the prenatal care it is possible to alleviate the mothers' fears and anxiety for pain at the delivery and even the experiencing of pain at the delivery, and consequently diminishing the use of medication before and during labour and thus decrease risks that medication represents for mother and child.

Unfortunately, insurance companies in their remuneration policies underestimate the physiological delivery. Consequently, the greater the pathology, the greater the prosperity for the maternity hospital. This shortsighted practice brings about costly consequences. On the contrary, physiological delivery should be rewarded by a premium, since the health of the mother and the child is a guarantee of a healthy population, lesser probability of future illnesses and lesser costs.

In recent years the birth rate in the Czech Republic has shown a rapid decrease. In this situation it is necessary to improve the quality of care for future parents especially with respect to the Hippocrates paradigm: "Primum non nocere." Ignoring the psychological dimensions of health and not including the psychological care within current health care might be considered harmful. Particularity when it is a commonly accepted fact that, during pregnancy and delivery, morphological, hormonal and psychological changes occur.

The new complex prenatal care and adjustment for delivery is widening the comprehensive health care including the primary prevention.

## I. Information

1. Information for the mothers about
  - a) the definition of health by WHO
  - b) the chart of women in labour and in childbed from the WHO documents
  - c) the complex prenatal care and adjustment for delivery
  - d) the breastfeeding
2. Verbal and visual information for mother and father about
  - a) somatic and psychological processes during pregnancy
  - b) the prenatal somatic development of the child
  - c) the prenatal psychologic development of the child
  - d) the prenatal child's learning abilities
  - e) the interaction with the prenatal child
  - f) the different types of deliveries
  - g) breastfeeding
  - h) the somatic care of the newborn child

- i) the psychologic care of the newborn child
  - j) correct nutrition during pregnancy and in childbed
  - k) the hospital environment and staff
  - l) possible harmful and undesirable effects of pre-delivery and delivery medication, offered for decreasing delivery pain.
3. Information gained from mothers and fathers, or other persons
- a) on the basis of conversation – individual, pair, group
  - b) on the basis of questionnaires, e.g.
    - what they need most urgently
    - what they expect from the course
    - what they are afraid of
    - what seems easy for them
    - which type of delivery would they prefer
    - if they want to breastfeed
    - if the father wants mother to breastfeed
    - what they know about the prenatal child
  - c) from psychological diagnostic methods, when indicated
  - d) from behavior observed in the mother
  - e) from behavior observed in the father
  - f) from the interaction observed between parents
  - g) from the interaction observed between mother and prenatal child
  - h) from the interaction observed between father and prenatal child
  - i) from the information gained retroactively from the participation in the course
    - about their satisfaction with the course
    - about what they missed in the course
    - about how they utilized knowledge and skills gained in the course
    - what helped them most
4. Information gained retroactively from the medical documentation about:
- a) the course of delivery
  - b) the applied medication and its indication
  - c) the post-delivery adaptation of the mother
  - d) the post-delivery adaptation of the newborn
  - e) initiation of the breastfeeding
  - f) the further course of breastfeeding
  - g) the early interaction of mother and father with child
  - h) the somatic condition of the newborn
5. Information gained retroactively from the psychologist's documentation about:
- a) the course of delivery
  - b) the behavior and experience of the mother during delivery
  - c) the behavior and experience of the father during delivery
  - d) the behavior of the newborn
  - e) interaction of the mother with the newborn
  - f) interaction of the father with the newborn
  - g) behavior and psychology of the newborn

**II. Training of techniques**

1. Relaxation
  - a) practised with mothers
  - b) practised with fathers
  - c) practised with both parents
2. Physical exercises
  - a) for pregnant mothers
  - b) respiration exercises for the different stages of the delivery
  - c) swimming in pregnancy
  - d) yoga
3. Breastfeeding
  - a) practice of the technique at the first breastfeeding immediately after delivery
  - b) practice of breastfeeding technique
4. Massage
  - a) practice of self-massage for mothers
  - b) practice with the fathers massaging mothers
5. Fathers (or accompanying persons) appearance and behaviour
  - a) during the first stage of delivery
  - b) during the second stage of delivery
  - c) during the third stage of delivery
  - d) immediately after delivery
6. The active cooperation of the mother and father (and / or accompanying person)
  - a) during the first stage of delivery
  - b) during the second stage of delivery
  - c) during the third phase of delivery
  - d) immediately after delivery
7. Communication with the child
  - a) practice of mental communication of the mother with the prenatal child
  - b) practice of verbal communication of the mother and father with the prenatal child
  - c) practice of touch communication of mother and father with the prenatal child
  - d) practice of interaction of the mother with the newborn after childbirth
  - e) practice of the father (or accompanying person) with the newborn after delivery

**III. Support of positive thinking and behavior in mother and father**

- a) to cope with fears, anxiety, and dread
- b) alleviate psychological blockage
- c) practise of positive thinking and attitudes
- d) practice of assertive behavior, especially in mothers
- e) choice of optimal life style

**IV. Use of complimentary techniques**

- a) phytotherapy
- b) aromatherapy

- c) musicotherapy
  - d) art-therapy
  - e) bibliotherapy
  - f) acupuncture
  - g) acupressure
- V. The individual care according to the mother's and father's needs**
- a) medical
  - b) psychological
  - c) social
- VI. Care for mothers with high-risk pregnancy**
- a) individual
  - b) group
- VII. Care for the social high-risk group of mothers (teenage pregnancies, single, with abortions in anamnesis etc.)**
- a) individual
  - b) group
- VIII. Care for the high-risk group of parents (underage, of high age, with handicapped child in the family, homeless etc.)**
- a) individual
  - b) group
- IX. Medical care in indicated cases**
- a) of the mother
  - b) of the child
- X. Psychotherapy in indicated cases**
- a) the mother
  - b) the father
  - c) the parental pair
  - d) the whole family

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