

Integrating Therapy with Emotionally at Risk Pregnancies

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Abstract: Three cases of unplanned and emotionally at risk pregnancies will be presented. The stages of psychological processing and preparation, using the prenatal stimulation model, to facilitate a healthy acceptance of the pregnancy, will be discussed. A framework of the stages of psychological preparation from acceptance of the pregnancy through an optimal integration of the experience of the past with the reality demands of the present will be explored.

Zusammenfassung: *Integrationstherapie bei emotionalen Risikoschwangerschaften.* Es werden drei Fälle von ungeplanten und emotionalen Risikoschwangerschaften dargestellt. Die Stufen des psychologischen Umgangs und der psychologischen Begleitung werden diskutiert, wobei das Modell der pränatalen Anregung verwandt wird, um ein gesundes Akzeptieren der Schwangerschaft zu ermöglichen. Es werden Rahmenvorstellungen für eine psychologische Begleitung von der Annahme der Schwangerschaft bis zu einer optimalen Integration vergangener Erfahrungen mit den Anforderungen der Realität entwickelt.

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Introduction

I will present three cases of unplanned, emotionally high risk pregnancies from my clinical practice as a psychologist in private practice in California.

Research has consistently demonstrated that physical and psychological preparation is needed to ensure the health of the baby. The need for intervention is essential when the pregnancy is unplanned or unwanted. I would first like to present a paradigm of psychological steps in pregnancy. In the first trimester, the most important task is for the pregnant woman and her partner to accept the reality of the pregnancy. Pregnancy is both a psychological, as well as a physical reality. Denial of pregnancy is documented in the literature by numerous cases of teenage girls rushed in with abdominal pain only to be give birth to a baby. Denial is often based on fear. Denial of fear may be an expression of inner conflict and creates

more anxiety than reducing and resolving it. In optimal circumstances, the first trimester is a time of joy.

Steps for Resolving Emotional Conflict in Pregnancy

The first step is recognition of the pregnancy, to come to a decision about it, and at times, the choice is to terminate the pregnancy. By accepting the reality of the pregnancy, and making a decision, attention can then be directed toward taking care of the pregnant woman and developing baby. Men generally lag behind women in believing the pregnancy is real. Frequently, a sonogram or fetal movements confirms the pregnancy and facilitates an awareness and acceptance of the pregnancy.

The second step is to accept the reality of the fetus. Parenting is a constant accommodation between expectation and reality, between the parent's projections about who they think the baby is and the baby's own nature. At mid-pregnancy, the combination of projection and reality is appropriate. Viewing the images on the sonogram can help the parents to psychologically differentiate between mother and baby and promotes healthy separateness of the baby's needs as separate from the mothers. Promoting the sense of separateness and addressing the union are important in healthy acceptance of the baby's needs and wellbeing.

Step three is to reevaluate the previous generation of parenting. During the middle of pregnancy, while the fetus is becoming accepted as a baby, it is appropriate for the parents to understand both the overt parenting they received from their parents, as well as the unconscious, unexpressed, covert expectations from their families of origins. It is at the middle phase of pregnancy that the pregnant mother reevaluates her relationship with her mother.

In step four: the partners reestablish their relationship. The goal for the expectant parents is to establish an emotional alliance, an agreement to communicate, to share emotionally and to help the other cope with the unfamiliar, stressful events, especially for a first pregnancy. The partner alliance facilitates growth and support as individuals, and through this connection, enables the parents to support the developing baby.

The goal of step five is to accept the baby as a separate person. Toward the end of the pregnancy, most parents are anxious about the birth process. Parents need to accept the impending reality of the baby and move from the fantasies held in pregnancy.

Step six is to integrate the parental identity. The goal for the parents is to learn to be connected from an empathic position, rather than from a needy merged position. Good parenting requires the ability to connect as much, or as little, as the child needs at each stage of development.

Through appropriate nurturing of the baby, parenthood has the opportunity to heal past wounds. The psychological task of pregnancy is to integrate experiences from the past with a healthy reality of the present. There exists little differentiation between the psychological development of the parents and the emotional well-being of the fetus/infant. By exploring the meaning of each of the psychological tasks and achieving some degree of resolution, parents are better able to cope with the new roles and changing relationships.

I would like to share three of the following cases of unplanned and unwanted pregnancies from my practice as a clinical psychologist.

First Case Example

Terri was referred for continued therapy following her treatment for poly-drug dependence. Her drug of choice was methamphetamines, referred to as speed. She was a twenty-four year old Caucasian, single woman who had been dependent on drugs for the last five years and had had a very disorganized life style during those years. She had one relapse at six months and was sent back to undergo relapse treatment classes. Following her relapse treatment, she began dating a man who had had a history of drug and alcohol abuse. She became pregnant in the relationship. She had had one previous pregnancy that she attributed to bringing her into treatment for her drug problem. While on a camping trip with her parents, she became ill. The parents, as well as the patient, believed that the bout of illness was due to the drugs that she had been using. The parents, worried and upset, refused to remain in a relationship with her if she continued using drugs. As a result of their determined position, she entered drug treatment and discovered her illness was due to a pregnancy.

The initial goal in therapy was to accept the reality of the pregnancy and support her in her direction, that direction was to have the baby. In the initial stage of her unwanted pregnancy, the mother was the patient, as she struggled with the reality of the unexpected pregnancy.

My position, at that time, is to support and in a sense merge with the patient in her struggle. Terri began to move forward in acceptance of the pregnancy; issue were identified and a process of resolution began. When I speak of a process of resolution, I am implying that the issue of pregnancy no longer brought forth the degree of physiological and psychological response. When a traumatic event occurs, the tendency is to withdraw from the painful event. The feelings of fear, doubt and shame can be so strong that they bring forth an intense physiological response. The sympathetic nervous system switches on and the fight or flight response takes over. It is through frequent addressing the fearful event that gradually the response diminishes and the patient is able to discuss the situation without the same physiological/psychological response. At the time of decreased response, resolution has begun. I now go into seeding; seeding an awareness of the baby's needs. Through resolution of her conflict she was able to begin to focus her attention to the baby, to begin an understanding and accepting the needs of the baby.

During the initial work in an unwanted pregnancy there is a sense or need to move the mother quickly to an awareness of the baby's needs, as if a time clock is ticking through these critical months. I fought against my own fear and anxiety and focused on cues that the patient was ready to make the transition from self to other. I began discussing the effects of long term unresolved stress on the fetus, and ways to reduce the stress and connect with the baby. At this time, I presented the Prenatal University interactive model with mother and father engaging in talking to the baby which continued up through the delivery.

Three weeks after delivery, I saw Terri and her husband with their eight pound healthy boy. Dad entered carrying the baby in an infant carrier. They were totally delighted. Dad who had been active in interacting with the baby during the pregnancy, was engrossed with his baby and ecstatic when the baby turned and alerted following delivery.

Unfortunately, the couple was to experience significant problems that would later lead to their separation and divorce. The father had had numerous arrests and a history of legal problems. He had two previous children, Terri knew of only one, and persistent difficulty in retaining employment. The couple separated when the father was arrested and placed in prison. The father kept up his weekly, Sunday evening calls to his then year old son. Terri stated that she didn't understand why he was so interested in this child, as he had completely ignored his other two children. I continued to see the mother and infant over the next two years. Her pediatrician was amazed at her son's advanced development and early speech. Mother continued to demonstrated a healthy, interactive style that promoted his emotional and intellectual development. On one occasion in my office when the baby was eighteen months old, the baby picked up each crayon and correctly identified each color.

Second Case Example

The Smith family I had initially seen when they brought their 4 year old son to therapy for his frequent, angry outburst and a problem with encopresis. I saw the child and his parents for several months directing them to parenting issues and a beginning resolution to the problem. Two years later, I received a call from the husband, requesting therapy, stating that his wife had suddenly rented an apartment and moved out. I initially saw each of them individually for one appointment, and then began seeing them together to begin the process of identifying the issues and on to resolution. Two weeks later, she moved back home. Not long after her move home, they came in to announce that she was pregnant and had informed her husband that the child was the result of an encounter with an old boy friend during their separation. She stated she felt obligated to inform her husband that the baby was not his child. During the marriage, the husband had been adamant that he was not willing, financially or emotionally to take on another child and that he resented the time already taken to parent their two young children. The wife stated in that session that she was not willing to terminate the pregnancy. The couple was obviously in crisis. I began seeing them frequently in this critical phase, as numerous issues needed to be discussed and some degree of resolution achieved. We had a couple in crisis, angry, resentful with an unwanted pregnancy and two small children at home needing to be raised in a healthy environment. Therapy in many ways is an art form; we can intellectually state what we do as health care providers, but it does not paint the entire therapeutic process. Through much work, including legal advice, they decided to remain together, work out their problems and raise the child as their own. The initial patient was the couple, and continued to be the couple, each with their separate needs. Dad needed support and recognition for his developing broad shoulders. It was essential that the parents be able to separate themselves and their feelings from the innocent baby.

Frequently the initial response when presenting the interactive stimulation model is one of doubt. Dad, in particular, was uncomfortable and awkward. However, with the help of the younger siblings talking to their new brother and encouraging dad to “talk to mommy’s tummy” and seeing the children’s excitement, the awkwardness for both began to dissipate. The physical and emotional closeness that ensued became self reinforcing. Gradually the months passed and dad’s shoulders grew even wider and he started talking about “it’s not the baby I have a problem with, is there going to be time for me.” During this stage in the pregnancy, the couple explored their relationship; as the husband softened, the wife became more thankful and loving which reinforced his acceptance of the impending birth.

When I saw the Smith couple following the birth of their son, dad was totally bonded to this new child. He entered carrying in his arms their month old child, he continued holding the child throughout the session. The parents state that he looks too much like their other children and are certain that he is their natural son. The couple continues to work on their relationship, making time and setting “dates.” The baby is now 1 year old.

Third Case Example

The last case of unwanted pregnancy, is a thirty seven year old career woman. I first saw Kelly in therapy two years before when she began preparing for her return to work following the birth of her second child. Parenting for Kelly, in many ways, was uncomfortable. Juggling a career and children was understandably difficult, but she expressed feeling awkward and unsure of herself as a mother. She identified having an unsatisfactory, periodically difficult relationship with her own mother.

When she became unexpectedly pregnant, both she and her husband were shocked and upset. They struggled with their religious beliefs and the fact that at no time was a third child ever considered. The husband who was usually supportive, became resentful and withdrawn. They decided to inform no one of the pregnancy and to wait for the results of the amniocentesis, prepared, if necessary, to terminate the pregnancy. I supported the mother, my initial patient, in her despair, doubts and pain of the impending decision. When news of a healthy child was announced, seeding began. Seeding is a process of consciously and on a deeper, unconscious level beginning to place awareness and slowly redirect focus from the mother to the developing baby and its needs. When Kelly and her husband decided to continue the pregnancy, rapid work needed to be done for both had been consciously unattached to the fetus, unable to become attached due to their decision to terminate the pregnancy. If “anything is wrong.” The initial support of mom began to be directed toward the reality of the developing fetus and the baby’s needs. I began discussing the research on the capabilities of her intrauterine baby, a process of balancing my therapeutic role with the ticking clock of her pregnancy. She attempted to mask her skepticism, but was quite interested in preparing her existing children for the birth of their brother. The focus changed toward her children’s acceptance of their sibling. Due to a threatened premature delivery, Kelly was taken off work and remained in bed rest for the last 8 weeks of her pregnancy. Her total time off from work was five months. She gave birth

to a healthy 9 lb son. I saw her with her three month old son just prior to her return to work. She talked of her enjoyment of motherhood and attributed the birth of her third child as enabling her to develop fully as a mother. The baby, whom she cradled in her lap, cooed and smiled. She described him as easy, calm and happy. She stated feeling totally comfortable carting all three children around and in preparation for her return to work had taken the children, baby included, by public transportation to the city, "to see where mommy works." She was tearful during the session about returning to her pressured, high paid job and giving up the special time she experienced at home with her children. Her husband who originally was withdrawn and resentful, had decided to take a paternity leave for 5 week to be with the children at his wife's return to work. I saw her last week. She was delighted in her husband's involvement with the children, and especially in the close relationship he had developed over the weeks with his infant son. During the summer, he frequently made play dates with his children's friends and the other "mothers." He couldn't get over all the attention he got when he took their infant son by himself, "the women just flock to me."

Conclusion

I would like to say that the outcome of these unwanted pregnancies was considerably better than I had anticipated. Pregnancy is a fertile time, where the stress of the changing roles enables the parents to be receptive on all levels of their consciousness. During this time, anything that facilitates a closer, more secure and positive experience has tremendous benefit for the developing baby. The model I used was the Prenatal University Model, an interactive, prenatal stimulation approach which was used to promote attachment during pregnancy.

I believe that other methods that help prepare the consciousness of the mother, father and baby are of benefit and can reduce the anxiety of birth and subsequent life experience.

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