

Methodological Levels in Pre- and Perinatal Psychology and Medicine

Rupert Linder

Abstract: It has been possible to acquire extensive insight into the relationship between prenatal and perinatal experiences and the course of later development, as well as the possibilities of therapeutic and prophylactic intervention in very different methodological ways. This great diversity of methods, however, makes communication sometimes difficult especially with colleagues in medicine, psychology and psychotherapy who are oriented to academic concepts of science. Since 2007, five different methodological levels (ML) in prenatal psychology have been formulated:

1. The quantitative level
2. The qualitative level
3. The level of empathic insight
4. The level of practical knowledge of professional groups
5. The level of cultural psychological comparison.

One-sided restrictions at the methodological level hold dangerous problems and decisively limit the quality of treatment and prevention and the validity of results. Furthermore it is clear that there are no alternatives to integration and balancing of the methodological levels in theory and practice, especially since the unborn baby is not able to choose or to limit himself to one of the levels. The importance for the practical work in the field of obstetrics will be emphasized.

Zusammenfassung: Auf verschiedene Weise konnten umfangreiche Einsichten in die Zusammenhänge zwischen prä- und perinatalem Erleben und späterer Lebensentwicklung sowie die Möglichkeiten therapeutischer und prophylaktischer Interventionen gewonnen werden. Die Vielfalt der Methoden erschwert jedoch den Meinungs Austausch vor allem mit Kolleginnen und Kollegen in Medizin, Psychologie und Psychotherapie, die sich an akademischen Wissenschaftskonzepten orientieren. Seit 2007 wurden fünf methodische Ebenen (ML) in der pränatalen Psychologie beschrieben:

1. Quantitative Ebene
2. Qualitative Ebene
3. Empathische Ebene
4. Ebene des praktischen Erfahrungswissens
5. Ebene des kulturpsychologischen Vergleiches

Die Beschränkung der Arbeit auf eine Ebene führt zu erheblichen Problemen und schränkt die Ergebnisse von Behandlung und Prävention deutlich ein. Auf der anderen Seite gibt es keine Alternative zur Integration und Bilanzierung der verschiedenen methodischen Ebenen in Theorie und Praxis, da das Ungeborene nicht in der Lage ist, sich für eine der Ebenen zu entscheiden oder sich darauf zu beschränken. Die Bedeutung für die praktische Arbeit im Bereich der Geburtshilfe wird herausgearbeitet.

Keywords: methodological levels, prenatal psychology, integration, prenatal care

Introduction

Several methodological levels usually have to be considered and balanced according to their respective significance. They have been named and developed during the last years, also during special congresses of the International Society for Pre- and Perinatal Psychology and Medicine (ISPPM), e.g. 2007 in Heidelberg.

Five methodological levels are important:

1. The quantitative level
2. The qualitative level
3. The level of empathic insight
4. The level of practical knowledge of professional groups
5. The level of cultural psychological comparison.

An approach including all these different levels is vital for sufficient dealing with pregnancy and birth, because therapeutic or preventive actions have to cover all aspects of the situation, particularly since the developing child does not yet have any direct means of codetermination.

In a group discussion about “Problems of Monolinear Models”, each participant could cast three votes on the question as to what would be missing if there were restrictions at the methodological level.

At the quantitative level (1), the individual characteristics, the individual situation of each person, the emotions and the complex interweaving at many levels are not sufficiently allowed for. It would not be possible to represent adequately individual development, the certainty of a ‘healing encounter’, by reducing the complexity. Would the reduction at this level not be more of an expression of defence? The problem of conflict of interests in scientific studies (industry). The danger of one-sidedness, care when generalising? It is often necessary to have a period of 20 to 30 years to obtain significant results. In the end with some things calculation is appropriate, with others emotions.

The restriction to the qualitative level (2) would harbour the danger that physical collapse is not detected soon enough. This could go so far that one could call it loss of reality. There is also the question of how it is possible to draw universally relevant conclusions from individual experience. And the question remains of how language can access unconscious processes.

Statements based on empathetic insight (3) can be inaccurate due to false interpretation, problems of dissociation on the part of the therapists and their subjectivity. Their self-perception and self-awareness are essential in precisely this area. It might be difficult to differentiate between pre-speech memory and reconstruction in hindsight. A postnatal trauma could be concealed behind a ‘prenatal and perinatal experience’. Myth creation could develop, especially with ‘charismatic teachers’. Certain types of therapists can selectively attract certain types of clients, which harbours the danger of false generalisation. So it is also possible that one-sidedness can prevail at this level; every level of perception is necessary and the restriction to level three alone could also be of a defensive nature.

In practical experience (4) it is exactly the wealth of experience of the midwife’s craft that should be considered. Important know-how can also be had from laymen. Fear and power are the two extremes that make this difficult to accept.



Impressions of the congress in Heidelberg: (1) participants (2) Prof. Otwin Linderkamp contributes to the discussion (on the right side in the foreground Rien Verdult, psychologist) (3) participants work out their votes, (4) the results after clustering (5) Hans v. Luepke, M.D. and Rupert Linder, M.D. during clustering of the results within the group (6) Prof. Lucio Zichella, professor for gynaecology and obstetrics in La Sapienza/Rome.

In cultural psychological comparison (5) literary reports from Africa were presented. Among others, trance was described as a culturally-overlapping therapeutically effective procedure. It is, however, often the case that there is a cultural dependence on effectiveness. The subjective views and existential orientation of the dyad patient-therapist are of great significance. Knowledge from this area is of course not transferable on a one to one basis to another. Here also lies the danger of an incomplete observation. In an additional category the importance of intuition was highlighted and the importance of introspection by therapists was emphasized. They have to be able to combine everything into an complete whole.

The analysis of the votes showed that one-sided restrictions at the methodological level hold dangerous problems and decisively limit the validity of the results. Furthermore it is clear that there are no alternatives to integration and balancing of the methodological levels in theory and practice.

Practical Aspects of Methodological Levels in Obstetrics and Psychotherapy

The integrated use of obstetrical and psychotherapeutic measures enables the integrated use of the five methodological levels. In this connection, economic and legal factors are of additional importance. The special complexity of the gynaecological examination and treatment situations requires a permanent observation of the different methodological levels and their integration and balancing. In the process, one level can be of more importance at times, as, for example, the level of quantitative measurement when ascertaining obstetrical findings, the qualitative level when ascertaining personal and relationship characteristics, the empathic level when ascertaining the psychological dynamics of conflict, the practical level when including obstetrical know-how and the level of cultural comparison when dealing with members of another culture.

The obstetrical consultation situation, which includes a psychotherapeutic aspect, contains a unique complexity with which the doctor has to deal in the course of his therapeutic duties. It is exactly this conjunction of the objects of care, the pregnant woman, the unborn child and the expectant father that requires an integrative overall view of all three. This has, especially in impending morbidity, to include the environment as well as the subjective inner life and the previous history of those involved. In this relation the self-awareness and self-reflection on the part of doctors and therapists are of great importance and of great relevance in particular for those clients with impending pathology. The systematic discussion of methodology should be continued in this area.

How Can the Balance of Methodological Levels Be Maintained?

There are again results from another group discussion on the topic 'How Can the Balance of Methodological Levels Be Maintained? The participants or small groups respectively could cast their own votes. Important prerequisites for the necessary inquisitiveness and candour are here assurance, self-confidence and the dialogical inner exploration of therapists. New assessment and further development can develop from self-reflection. Profound self-awareness is a prerequisite for impartial empathy towards patients. The patient's biography can be understood in

accordance with the dialogical principle. Access to the different levels can arise quite spontaneously, in time the assurance increases and allows the possibility of conscious reflection. As special topics arose the question of how non-verbal communication can be documented, and the ascertainment that gender specific means of access are possible.

Physical Illnesses during Pregnancy with Psychosomatic Aspects

In the following psychosomatic problem areas, psychological aspects play a greater or lesser role in each case. It is necessary to clarify these individually in order to gauge the possibilities of psychotherapeutic/psychosomatic treatment:

1. threatened miscarriage
2. status after recurrent miscarriage
3. morning sickness
4. premature contractions/premature birth
5. preeclampsia
6. HELLP-syndrome
7. “symphyseal slacking”, pelvic pains
8. breech presentation
9. dealing with overdue delivery
10. after birth: mastitis

Perceptive Attitude in Gynaecological Practice

Prenatal psychology has taught us how important the early pre-speech stage is. Pre-verbal experience can express itself in dreams, emotions, moods, bodily sensations and feelings as well as in scenic realization. Here, I want to include expressly associations and re-stimulation. We know from the experience of Balint groups that the background of a problematic situation can reveal itself in the group. And it is exactly these aspects, which are sometimes seen as chaotic and perhaps hard to digest, that are of psychodynamic importance. They are therefore an important diagnostic instrument.

This can also be observed in the subsequent case histories. There aren't always instant right answers; some questions remain open. Sometimes it isn't possible to pigeonhole things. This is why openness, enduring not knowing and repeated appointments are so important. What might remain unclear in one session can be understood in a later one. What isn't possible in one session can happen of its own accord in a later one. Gynaecological action can only arise from an understanding of the whole situation based on the interactions of the relationships in consultation. Here the fundamental setting of gynaecological practice is analogous to free-floating attention in psychoanalysis, although there the patient brings into the session the totality of a concrete life situation in free association with different levels of his communications and behaviour, including bodily expressions. As a result of the great responsibility in understanding and taking action, a special intensity develops in the diagnostic and therapeutic situation. This exceeds the bounds of the normal psychotherapeutic situation and requires of the gynaecologist great presence and the permanent re-evaluation of experiences and perceptions.

Case-histories deal with ongoing therapies, as interconnections can then be more vividly and authentically described. I would like to point out that I have to present the complexity of the cases as they exist so that you can comprehend how it is eventually possible to distinguish the really important dynamically effective aspects which then facilitate sensible action.

This happens in a kind of circular process. When one particular aspect becomes comprehensible, the therapist can then provide a stimulus relating to it, creating a new situation that facilitates new possibilities of understanding, and this in turn activates a further level. This process repeats itself several times. The whole thing has similarities with the mechanisms of a psychotherapeutic process, only all levels of reality are present. In addition, it could almost be said that the structure of this process is similar to the dialectic process described by Hegel with the progression from thesis to antithesis and then to synthesis, which in turn becomes the starting point for a new dialectic triple step.

Case History I – Denial of Pregnancy in the Prior History and Its Repercussions

Mrs A., in the second half of her twenties, lived together with her boyfriend. She came to me in the 24th week of pregnancy with severe morning sickness requiring a certificate of illness. She was in her third year of nursing training. It soon became obvious that she also had a drug problem. She had smoked a lot of marihuana. In passing, she said that she had always had problems concluding things. This was a spontaneous statement, the significance of which would later become clear from her biography.

To begin with, I gave her a certificate of illness in order to take pressure off her. She wasn't able to give up smoking for the whole length of the pregnancy. We kept talking about it: sometimes it seemed as if she had managed to stop, then it was clear that she hadn't. Luckily, this point turned out to be not that important as the child was developing well. The ultrasound examinations never revealed any developmental deficits. I gave her an anamnesis questionnaire about her biography to fill in. These questions appeared on it:

1. Peculiarities during the pregnancy (of your mother with you)?
2. How did your birth progress?
3. What about the months afterwards?
4. What do you know about your parents' relationship at the time?

The prior history of this patient is really special because on the questionnaire she described how she had been conceived. Her mother had had her first child at the age of 17. She was the second child, conceived during a chance encounter with a man at a summer festival 200 km away. Her mother had denied the existence of the pregnancy, although she had already had a child and must have been familiar with all the changes and the child's movements within her. Apparently, no one around her had noticed anything. There must have been some awareness somewhere, but it had quickly vanished. In the end, she went to hospital with suspected appendicitis. This was the birth of the woman who was now herself pregnant. Therefore, it was fitting that she said "I can't conclude things". I find this very logical in view of the mother's transference when seen from the trans-generational viewpoint.

Now, this is how it continued: unfortunately, she developed severe gestational diabetes. I am not depicting this from a theoretical viewpoint, but from the practical viewpoint as things developed in my practice where all the background elements of the different levels are always present and significant: the quantitative, qualitative, empathetic and the others. In many respects Mrs A. had, as could be expected from her prior history, a way of refusing to believe things. She visited the diabetes doctor irregularly – I worked together with an internist diabetologist. She also had difficulties keeping to agreements and missed appointments because “her mother or friend hadn’t given her a lift”. These are obviously the kind of things that frequently happen when there is a background problem with drugs. To begin with, she often didn’t have the sheets with her daily blood sugar measurements with her. She gradually managed to improve measuring and bringing the results with her.

For a long time, she was undecided if she wanted to have a house birth or not. But in the end, the diabetes and the necessity of intensive monitoring of the child made delivery in the clinic advisable.

The delivery date was one week overdue, which, in the case of diabetes, required greatly increased attention and patience. However, the delivery went well and Mrs A. was really very happy and contented.

I have to add here that it wasn’t possible for the patient to come to terms critically with her mother because she was too dependent in reality on her mother and her support. I did, however, keep bringing up the subject cautiously.

I hope it has become clear that the whole situation of the patient and the supportive care during pregnancy was overshadowed by the denial situation in the time before her birth. Knowing about this facilitated caring for her as well as possible under the given circumstances. Without this holistic approach, there would have been a danger that individual aspects could cause one-sided interventions which in their turn would cause a chain of further reactions which could have had severe consequences.

Case History II – Repercussions of Being Unwanted in the Prior History

Mrs B. was 43 years old when she came under my treatment two years ago. Her boyfriend lived in another flat and she was newly pregnant. It was her second pregnancy. Her first child, a daughter, had been born 17 years earlier. She required prenatal diagnosis on account of her age. Due to anomalies in the region of the neck, I advised further clarification by standardized ultrasound screening with a colleague. He then calculated her risk factor. Going by age alone, this was 1:25 that the child had Morbus Down (Down’s syndrome) and after the examination 1:15, i. e. even higher. We then discussed the matter, and after a detailed process of information she wanted no further diagnosis carried out. It was noticeable that she always had a radiant smile on her face when she believed in the intactness of her child. Parallel to this, there was a serious crisis with her partner that led to a separation. She had to go through a lot during the process. In relation to this, premature contractions set in, which, however, disappeared after the strain had been relieved by the discussions and temporary certification of illness.

She was always able to regain courage and bore the child normally. The collapse came 6 months after the birth. She then had a mental breakdown and I made an

application for formal psychotherapy. In this context, it first became apparent to what extent the issue of being unwanted was important to her: she was the fourth child; the mother had got pregnant against her will by her alcoholic partner. She kept arriving at the point where her feeling of security threatened to break down, which resulted in her feeling that she simply wasn't able to look after her child. She said she sat in her flat and could do nothing – regardless of whether the child cried or not. She had also started smoking heavily again and wasn't eating regularly so that she finally weighed less than 50 kilos. This depressive psychosomatic reaction had been triggered by the fact that the father of her child had promised her a certain sum of money and not kept to it. She felt that she was just hanging in midair. The non-appearance of the money had triggered her own prior history of being unwanted.

Another impression was that when she railed against the father in her distress, often the child was with her and it always screamed. We were then able to discuss this and she was able to understand it. Of course, she still has much to come to terms with and that can happen in the continuing psychotherapy.

Case History III – The Effects of a Lost Twin in Prior History

Mrs C. was 27 and had got pregnant unexpectedly. She hadn't expected it because she suffers from Crohn's disease and had had 20 operations on her abdomen and intestines – including an anal extirpation – and lived with a stoma. She came recently, in the 24th week of pregnancy, complaining of stomach pains and wanting a certificate of illness. This seemed to me to be a sensible way of relieving strain as she seemed to be overstressed and there was a suspicion of premature contractions despite her fundamentally marked commitment. The emotional and/or physical overtaxing of women is the most frequent cause of premature birth, and this is often underestimated. After two weeks everything had calmed down.

Her record revealed that she had previously suffered from pronounced neurodermatitis and it transpired that her mother had assumed she had had a miscarriage due to bleeding early in the pregnancy and thought the pregnancy was over. The mother had turned out to be wrong and in the end the patient had been born. The situation of the lost twin and her own endangerment was discussed with her at length. She had made it but her twin had not. She was able to take in the interconnections. I think that the therapeutic efficacy of this work lies in the fact that people can talk about the traumas and share the feelings. So it was in this particular case and this is why I'm not really worried about the further progress of the pregnancy. She is now in the 34th week of pregnancy.

The question of the form of birth, i. e. how she is going to deliver the child is still unresolved. Her surgeon, in whom she has great confidence due to her years of illness, has voted for a caesarean section due to the scarring caused by the operations for Crohn's disease. My idea was rather this: the womb is the only undamaged organ so why subject it to this operation? I have now spoken to the chief physician of one of our gynaecological clinics – in this situation you're always the go-between – with whom it was possible to discuss the situation. He agreed with my opinion. It is, however, possible that the patient herself will want to have the caesarean section due to the traumatization of the many operations, in the

assumption that her maltreated pelvic floor would be the better spared. There is to be further discussion here.

Concluding Remarks

An important observation in bonding analysis is that burdens in the prior history of the expectant mother and her mother are of far greater significance in the ongoing situation than is assumed in the normal view of maternity care, so confined to the present situation. This observation can be fully confirmed from the viewpoint of the psychotherapeutic-psychosomatic gynaecological practice, only here is even more complexity in the consequences of burdens from the patient's own prior history as well as the mother's, among others in the prevailing corporeality. It is evident that the early burdens shape the whole life situation of the expectant mother and the arrangement of her relationships. The awareness of the trans-generational depth of the prevailing situation makes it possible for the gynaecologist to take into consideration the different existential and methodological levels and so find a new balance between these levels. This is what makes possible holistic understanding of the patient's complex reality and so appropriate action.

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Late abortions and premature births – general information

Erich Saling M.D. FRCOG, Jürgen Lüthje MD, Monika Schreiber M.D. Institute of Perinatal Medicine, Berlin, Germany

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Correspondence adress: *Rupert Linder*, M.D., Specialist in Obstetrics, Gynecology, Psychosomatic and Psychotherapy, President of ISPPM, Goethestraße 9, 75217 Birkenfeld, Germany, Telephone +49 7231 482223, Telefax +49 7231 472240, www.isppm.de, E-Mail post@dr-linder.de