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Conflict of Pregnancy – Experiences from a Gynaecological and Psychotherapeutic Practice

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Abstract: In gynaecological consultation various dimensions of life of women and families become concentrated, for example contraception, fertility treatment, wanted or unwanted pregnancy. Using five examples I will show you the wide spectrum of conflicts in pregnancy that is possible, highlighting possibilities of support. In reflections on the case histories psychodynamic aspects will be explained further. When dealing with pregnant women, particularly in conflict situations, emotional openness and solicitude of carers is most important. This is required immediately and in sufficient measure. In situations such as those described, 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 backgrounds. The openness of the carers 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.

Keywords: Pregnancy conflict, psychodynamic aspects, complexity, demands for caregiving, solution oriented approach

Introduction

Pregnancies result, hopefully for the most part, from love. When one considers them in a wider concept than mere 'Eros', desire, the different facets of love become even clearer.

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 ass-hole!", 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 realises 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 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 gynaecological 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 bosom, pubic hair, menstrual cycle, the strong psychic disturbances during this time . . .), contraception or the reverse side of this wish: desire for a child or preparation for a pregnancy.

In gynaecological consultation various dimensions of life are concentrated – 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, in the overall state of her health. It is therefore necessary to take into consideration the overall situation at every level: psychological, social, biographical, somatic and biological. In order to achieve an integrated starting point for consultation all these levels have to be considered, not selected or segmented but in total and integratively. It is necessary to reproduce in concrete terms the 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, nor given due importance in public discourse. Therefore behind a (supposedly) simple statement such as "the man doesn't want children" a large and complex reality, which is not easy to set forth and understand, can be concealed. It could be to do with partner conflict, as in examples **B** or **E**, 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 man's problem or trauma (also **E**) etc. Despite this complexity, which can of necessity be grasped only partially, though as much as possible in its central questions, extremely significant decisions have to be formulated and taken, as the examples make clear The dimension of time is significant as it can be helpful in providing an impulse for development. Sometimes women are relieved when the 12 weeks have passed because this takes the weight of the external decision off them of not having to justify themselves to their partners any more. The time factor is however often limited 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 present you with the wide spectrum that is possible. This also serves as an introduction to and preparation for this topic. 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 can comprehend the diversity of social, emotional, relationship-related and cross-generational facets.

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

One year afterwards: "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: mucus production in the middle of her cycle, she sensed the fertile days and two months later was pregnant. She suffered occasionally from circulatory trouble, "I feel like my batteries are totally empty and 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: "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. My friend lives several hundred kilometres away. I know from a friend 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 foetuses was conspicuous 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 conspicuous child 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.

Mrs **B**: In the second half of her twenties, from a near East European country. 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. At the time she had gained 30 kg in weight during the pregnancy. "I want an abortion." On being asked about her situation in life: her partner had left the decision to her. "Sometimes there are fights in the relationship, also 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 earnest 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 to her parents in her home

country. She occasionally suffered from premature contractions, the ektocervix was at times markedly shortened with a crater formation in ultrasound examination. Using *Tokolytikum oil* (Stadelmann) 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 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, "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.

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 inconsistent: 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: "A child isn't convenient now". The consultation did not last very long.

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

Mrs **D**: Had two children, two and three years old, a warm-hearted, emotionally receptive and motherly-looking woman. 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: Some days it's better but she still thinks every day about having done the wrong thing. "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 had 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 do some work again. She felt better and she no longer needed any therapy sessions.

Mrs **E**: Early thirties, already mother of two children aged 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, since the day before, had had abdominal pains on the right-hand side: the partner had said: "Either me or the child." The ultrasound examination showed two amniotic sacs. Three days later the partner came along. He said accusingly that he was being neglected: "The lives of four people are being destroyed – mine, hers and those of the children already there ... I don't want 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 down. The friend 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: 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 kilometres away. As a result of abdominal pains paired with a relatively intact ektocervix. 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: The ektocervix 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 to the father of the twins came about ("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). 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. 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 mobilised, 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 recognised as conspicuous (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 (now 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 also enables 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 bring her son back. Nonetheless her emotional state is depressed during the whole pregnancy. Not until its end, as 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 carers, 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 cannot be touched upon but seems to lie in deep unconsciousness. 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 empathic 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 fairytale. 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 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 carers (practice staff members, gynaecologist, therapist, clinic, advisory centre, 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). Decisive were Mrs E's good emotional ties to both her unborn children. Finally such an example can show how narrow the line sometimes is between good, successful and healthy development (mentally and physically), and severe, possibly life threatening complications.

Final Considerations

Here can be seen how important emotional openness and solicitude of carers is when dealing with pregnant women, particularly in conflict situations. This is required immediately and in sufficient measure. In situations such as those described, 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 backgrounds. The openness of the carers 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.

During the congress *Love, Pregnancy, Conflict and Solution – Exploring the Psychodynamics of Pregnancy Conflict* of ISPPM in 2006 it became very clear, what strong grief couples suffer about a lost child, even after an induced abortion. Additionally it was highly evident and important, how the fact of being an unwanted embryo, or even having undergone an attempted abortion, imprints the future life of these individuals. Those events can be a most relevant cause of ambivalent dealing with contraception and thus brings them again into a situation of an unwanted pregnancy – in this case with a new child within the womb. This is an important and new aspect relevant to this issue.

Pregnancy induces an unconscious reactivation – albeit impinging on consciousness – of early prenatal affects. It is precisely the time during pregnancy and after that, with relationship-oriented accompaniment as well as an increase in value of actual relationships, affords great potential for development of the prospective parents at every level.

It becomes clear from the examples that the actual 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.

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