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The Psychological Aspects of Premature Birth

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Introduction

Psychological aspects play a role on various levels with the prematurely born. They affect the duration of a pregnancy as influenced by the mother and are significant in dealing with the premature child. The psychological viewpoint is also a central issue in determining the implications of prematurity. With two-thirds of all perinatal mortality cases attributable to prematurity (Jung 1975, p. 177), obstetricians have recognized prematurity as an urgent problem for years – unlike their colleagues in psychotherapy. A tremendous amount of progress has been made in dealing with the somatic problems which can arise in connection with prematurity. Beginning around the mid-seventies, experts also began to attach greater importance to the psychological factors which may incline a woman to give birth prematurely (Jung 1975, p. 179) as well as to the necessity of taking psychological considerations into account when dealing with the prematurely born (Steinhausen 1976).

All major long-term studies of the psychological impact of prematurity have shown that the parents' socioeconomic situation and their ability to respond to a child are critical in determining whether premature children can overcome the somatic, behavioral and psychic deficiencies they display as compared with full-term children. These studies indicate that premature children have to compensate – psychologically and in their relationships to others – for the unusually short duration of the pregnancy, and help is required in overcoming the special adjustment problems faced by such children (Sameroff 1981). These conclusions were confirmed by further studies demonstrating the exceedingly positive effect of early psychological support on the subsequent development of premature children (e.g. Solkoff 1969; for an overview, see Steinhausen 1976). In light of these findings, experts began to call for recognition of the emotional and psychological needs of the premature child, drawing special attention to the importance of protecting the relationship between mother and child and the need for close contact displayed by both (Freud 1980, 1981, 1986; Meves 1976; Rice 1986; Bender 1988).

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I nonetheless have the impression that a discrepancy exists between theoretical knowledge and the practical application thereof. Although there can be no argument that psychological factors can contribute to prematurity (e.g. Blau 1963), experts often fail to diagnose the necessity of psychotherapeutic treatment, and psychotherapists today are not yet sufficiently familiar with special psychotherapeutic techniques for pregnant women. Because of their basic psychoanalytical orientation, psychotherapists have a long-term perspective, whereas psychotherapeutic help for women experiencing difficulties during pregnancy entails treatment focused on a specific conflict. There is much room for development in this field.

One of the aims of this paper is to improve cooperation between instructors of childbirth classes, obstetricians, pediatricians and psychotherapists. I would like to begin with the psychodynamics of the birth process itself, an area that many are not sufficiently familiar with. I will then give an example of psychotherapeutic help for a woman whose pregnancy appeared likely to end in premature birth before briefly discussing options available in child psychotherapy. In conclusion, I will depict the continued influence of perinatal impressions on adults' perceptions of themselves. Although neurological and psychiatric examinations of premature children are said to show that, provided outside circumstances are favorable, most developmental deficiencies have been overcome by the time these children start school, it is perhaps not common knowledge that premature birth, like any other birth experience, very often plays a role in adults' perceptions of themselves and in their coming to terms with their own identities. While this does not necessarily indicate a pathology, it does once again illustrate the importance of dealing with prematurity from the psychological point of view.

The Psychodynamics of the Birth Process

Even today, reports in prenatal psychology on the influence of early prenatal or perinatal experiences are met with some degree of astonishment and incredulity, if not outright rejection. This reaction stems from our conventional understanding of the self, according to which psychological development proper does not begin until the second or third year of life, the earliest point to which our personal memories extend. Today we can see the truth in this approach more clearly if we equate psychic life with ego-reflexive consciousness and the faculty of speech. However, prior life does not constitute a tabula rasa of complete unconsciousness, but, as we can now say with certainty, the intensive emotional, sensory and holistic experience of the newborn and the unborn child. This level of affective consciousness is characterized by a subtle psychic capacity to differentiate, the ability to learn, and the capability of reacting on one's own. In neurophysiological terms, this corresponds to a functional focus in the midbrain, which shifts more to the cerebral region during the first year of life (Bronson 1982). Birth is one of the major elementary experiences of the self and the environment at this level of affective consciousness, an experience based on a fundamentally positive or negative prenatal relationship to the mother. During the birth process, one of the first major experiences of the self in all emotional and

sensory areas, the prenatal relationship is converted and transformed into the postnatal relationship to one's mother and the environment.

All of these processes and experiences are stored at the level of affective consciousness, as can best be imagined by someone who has witnessed the actualization – often over hours or weeks – of details relating to the birth process. Actualization of this kind takes place in modern experiential therapies, in particular, in primary therapy and psychoanalytical regression therapy. Such therapies show that an entire cosmos of impressions, emotions and behavior is stored in us. As I have already mentioned, neurophysiological studies indicate that brain activity is centered mainly in the midbrain and the right side of the brain around the time of birth (Bolle 1988, p. 142). Birth regression leads to corresponding changes in brain current patterns and hypnosis-like changes of consciousness. Patients always require a certain time to emerge from birth regression. Comparisons with birth records in numerous cases confirm beyond a doubt that the realia of prenatal and perinatal experience are reawakened in these birth regressions (Cheek 1974, 1986; Chamberlain 1990).

Premature births are typically characterized by prenatal and perinatal complications. Being more dramatic, perinatal complications are more obvious and thus receive greater attention. Nevertheless, a considerable number of premature individuals who have examined their prematurity from a psychological perspective are convinced that difficulties in their relationships to their mothers prior to birth were decisive in their cases. They feel that they chose to be born prematurely because their existence in the womb had become unbearable as a result of problems stemming from the mother and a lack of stability.

The dramatic nature of the processes experienced at the level of affective consciousness renders the marked persistence of perinatal impressions more understandable. All evidence suggests that the activity of birth is a significant contributory factor in determining the basic configuration of the ego feeling. Where massive fundamental emotional forces and structures are involved, these prevail even in the conditions of everyday experience and behavior. This explains observations to the effect that the peculiarities of one's birth can be reconstructed directly from an individual's behavior or figures of speech. This phenomenon is especially striking in the prematurely born, as has been repeatedly reported. Verny concludes from his observations of premature children that they "always feel pressured and tormented. This feeling of never being able to catch up and keep up is, I think, a direct consequence of their premature birth. They began life feeling hunted and now, many years later, still feel the same way" (Verny 1983, p. 89).

The most extensive observations in this field have been compiled by Ray and Mandel, who view feelings of weakness, smallness, fragility, incompetence and helplessness as typical of the prematurely born. The experience of being in an incubator can later lead to the feeling of being unable to make contact, of being seperated from others by a wall. Analogously to the birth trauma, this is known as the incubator trauma. In the following example, a patient discusses how her relationships are influenced by her birth:

> The way my birth affects my relationships is that I seem to get only so close and then create a glass wall. I never seem totally bonded with a man. I want to get married but create men who don't want to, or that I don't think are good enough. I have been very independent and want to prove that I can do it myself financially. I love having lots of people around and being the focus of attention, yet feel embarrassed when it happens. I seem to frighten lots of men like I did my father and my obstetrician. We end up in a look-but-don't touch relationship.

Another patient reports:

> I was two weeks premature and only weighed two pounds, four ounces. My parents separated when I was in the womb. I was plunged in cold water to get me breathing. For two to three days I was in an iron lung, then in an incubator. The way my birth has affected my relationship is I've always felt more comfortable alone, I like people, but feel like I'm imposing or not wanted. I tend to rush into relationships then wonder why I'm there. I feel comfortable and close to women, but don't understand intimacy or bonding with men. I tend to keep myself aloof and separate a lot, invisibility equals safety. I get "plugged-in" when I feel I'm not getting what I want, so I don't ask – do it myself. I try very hard to please in overcompensation for feeling like an imposition. It's difficult for me to surrender totally, especially in sex: I fear men will hurt me when I'm vulnerable, or be insensitive. I hate being cold, feel unloved, uncared for, manipulated. Life is unfair and disappointing, depressing and sad.

A third patient explains:

> I'm not touched enough. I feel a lot of anger in relationships. I want love but don't know how to receive it. I'm very independent, I love being in love. I want to be touched and held but I didn't know how to accept it before rebirthing. Now I know how to accept. I used to carry my incubator around with me for forty years. I'm now shedding it. (Ray, Mandel 1987, p. 77 ff.).

In conclusion, the authors again enumerate the characteristics typical of the experience of the self for the prematurely born (Ray, Mandel 1987, p. 82): such patients feel immature in relationships, are extremely vulnerable and often feel small and insignificant. If they were kept in an incubator for a long time, they may feel easily separated from others and alone, react fearfully to contact and feel easily observed and criticized.

These impressive instances of the continued psychological affects of the perinatal situation on the prematurely born once again illustrate the tremendous importance of psychological care and support for prematurely born children, especially in their relationships to others. My idea is that basic emotional patterns which have been deformed by perinatal traumatization can, through an infinite number of interactions, be worked out and integrated into opportunities for more mature relationships. If the trauma cannot be overcome in relationships, the traumatic engrams remain separate from the normal experiential process and can then break through like foreign bodies in stressful situations in everyday experience or even find expression in the form of bizarre character traits, preferences, sensitivities and peculiarities.

It is certainly no coincidence that the patient described in the first extensive report on treatment necessitated by the continued effects of a birth trauma on later life – which I will describe in the following – was prematurely born. Pre-

maturity itself is an unfavorable factor in the integration of traumatic emotional perinatal experiences.

Psychotherapeutic Help when Prematurity Threatens a Pregnancy

As I have already suggested, psychotherapeutic help during pregnancy would certainly be called for in a great many more cases than it is presently provided. During pregnancy, a woman must come to terms with her femininity and the changing roles and new identity which accompany motherhood, making it a time which offers very special opportunities for psychotherapeutic help (e.g. Hurst-Prager 1989). Specifically, it should be kept in mind that pregnancy and the expectant mother's anticipation of birth mobilize the engrams and memories stored at the level of affective consciousness relating to her own prenatal experience and birth (Braasch 1991), which can provide orientation in offering support.

"Psychotactile" contact to the unborn child, developed by Frans Veldman, appears to represent a special new approach to attending throughout the prenatal and perinatal phase to women requiring special care during pregnancy. According to Veldman's observations, we are all capable of depth communication; it can also take place between mother and child prior to birth and is as a rule more or less submerged as a result of our rationally oriented socialization. Depth communication can also be seen in contact between children or dancers or in the interaction between acrobats. This psychotactile or haptonomic contact (Veldman 1988), which can be practiced, may be a great help to the mother in establishing emotional contact to her unborn child. Good emotional contact fosters relaxation and is necessary if pregnancy and birth are to follow a natural course.

An obstetrician from Düsseldorf named Potthoff recently reported on the use of the haptonomic method with the prematurely born. As a means of diagnosing a woman's relationship to her unborn child, Potthoff asks patients to do spontaneous drawings illustrating "How I see myself within my family today". I would now like to summarize his casuistic example:

A twenty-six-year-old woman was experiencing premature contractions in the fourth week of her second pregnancy. The woman's drawings made the lack of contact in her family very apparent. Moreover, she was not in touch with either her own body or her child. Practice in haptonomic contact enabled her to establish a relationship to her unborn child. The contractions abated, and no further treatment was required. The picture of the family which she subsequently drew was completely different. Contact had been established.

Potthoff summarizes his conclusions concisely: "This example illustrates in a very striking manner what I had also been able to observe in other women who experienced contractions prematurely: these contractions express an unconscious rejection of or failure to accept the child. If the pregnant woman accepts her child and has good contact to it, the uterus becomes soft and the premature contractions stop" (Potthoff 1989, p. 4). It should be added that ambivalent feelings towards an unborn child are often caused by serious problems in a woman's relationship to her partner; another reason for such feelings – one which is en-

countered frequently and should not be underestimated – is that young couples are largely left on their own when it comes to the task of raising the next generation of our society, while they are at the same time often struggling with the tremendous burden of establishing their material existence.

Child Psychotherapy for the Prematurely Born

The options available for helping the prematurely born through child psychotherapy still find far too little application. The disappearance of neurological peculiarities in such children is cited as evidence that further help is unnecessary. In my opinion, too little attention is paid to psychological repercussions such as anxieties and insecurities. Child psychotherapy can offer a great deal of help in such cases. Dowling (1987) vividly describes what is known as the tunnel game as a means of diagnosing and reviving birth experiences. Equally impressive are the cases described by the American primary therapist Emerson and the success he achieved with therapy (1989). Emerson developed a kind of pressure massage which transports babies or infants back to the birth process, allowing them to process traumatic engrams. With older children, he sets up games designed to work out prenatal and perinatal traumas, much like Dowling. The chance of positive results being achieved through psychotherapy is much greater with children than with adults, and timely intervention can prevent much unnecessary suffering, as the following example shows.

Verny (1983) reports that a nine-year-old boy named Ricky suffered from terrible nightmares: "Every night, as soon as he fell asleep, he began flailing about and cursing, making use of a vocabulary that extended far beyond the limits of a nine-year-old. Even more peculiar was the shouting which ensued. Ricky started screaming out loud. Sometimes he also spoke of a strange light and seemed – so his mother thought – to be speaking a foreign language" (Verny 1983, p.90). The mother gradually realized that her son was reliving elements of his birth. Simply being able to understand the boy's fears can have an enormous therapeutic effect.

Adult Psychotherapy for the Prematurely Born

The case cited by Verny bears a certain resemblance to the first known case of psychoanalysis involving a prematurity trauma, reported by the Hungarian psychoanalyst Hollos. The patient, born at eight months, was convinced that he was mentally and physically inferior because of his premature birth. His symptoms included fits of chaotic rage and discontent, with symbolic destruction of himself and his parents. He also suffered from fear of arriving too early and acting prematurely. He was never able to determine with certainty whether it was time to end something and also suffered fits as soon as he finished a job. This was a very clear case of the engrams in the affective consciousness being directly beneath the surface of the patient's ego-reflexive consciousness and almost constantly manifesting themselves in his current behavior and condition. Treatment basi-

cally consisted of helping him to complete his birth feeling in a symbolic manner (Hollos 1924).

Traumatic prenatal and perinatal experiences are usually entangled and interwoven with later traumatic experiences in a complicated fashion, making the psychological repercussions of birth typically less obvious than in the case cited by Hollos. Nevertheless, as birth conditions are of fundamental importance for the configuration of the ego feeling, a premature birth is always a pivotal point in any later analysis. In psychodynamic terms, it is significant that a non-integrated premature birth, coupled with anxiety, changes the background against which subsequent stress is experienced. Incidences of stress may then be perceived against the background of primary experience, rendering them more difficult to process. A burden which could be overcome if initial circumstances had been more favourable can lead to decompensation. On the other hand, prematurely born individuals may also have a feeling of special strength, viewing themselves as invincible since they overcame an unusually rough start in life.

For psychotherapy to be successful, the repercussions of the premature birth must be understood, for even relatively slight disappointments in one's current situation and in the relationship to one's therapist can actualize the insecurity and vulnerability of the premature birth. In approaching the situation through therapy, understanding must be demonstrated in establishing these connections; otherwise, there is a danger of the patient reenacting his premature birth and ending treatment prematurely. I have the impression that the impact which early affective engramatic patterns can develop in the therapeutic setting is always underestimated, leading to the danger of counteraction and repetition in therapy. There is always the possibility of a latent suicidal tendency with late prenatal or early postnatal stress. Another typical way of processing a traumatic birth is to use role reversal to bring the partner or possibly the therapist into a dependent, vulnerable situation, making the other the one who has to suffer through the traumatic situation in representative repetition.

This became clear to me with a patient who, in a role reversal of this kind, always had girlfriends who were particularly isolated, abandonded and uncared for. He took care of these partners selflessly until, in a sudden turnabout, he was the one abandoned, expelled and uncared for. All of this took place on the level of very archaic, emotional feelings. The patient thus reenacted both sides of his premature birth experience – on the one hand, being set into the world early, on the other hand, being taken care of by his father, who looked after him very attentively. The persistence of a pattern of this kind became clear to me when I learned that upon the birth of his daughter, this patient arranged an irrational emergency situation which entailed his having to take care of his daughter just as he had been cared for by his father.

Concluding Remarks

Our considerable knowledge of the psychological factors relating to premature birth often fails to be converted into responsible action. One important reason for this failure certainly lies in the fact that the fundamental importance of the

earliest perinatal experience for our perceptions of the ego and life in general is underestimated by all. Were the findings of prenatal psychology on the significance of the experiences at the beginning of life to receive the recognition they deserve, the necessity of close cooperation between midwife, obstetrician, pediatrician and psychotherapist would be immediately apparent. It is a question of coming to terms with the conditions of one's own birth, thereby clearing the way for meaningful action. I envision midwives, instructors of prenatal courses and obstetricians being able to take over a great deal of the clinical psychotherapy for expectant mothers and to conduct it independently, provided they are supported by supervision groups according to the Balint system.

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