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Ethical consequences of prenatal and perinatal psychology

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Abstract

This contribution deals with the ethical issues directly related to prenatal and perinatal psychology that views human life as encounters, continuity and dialogue.

The success of the life of a newborn baby is already predetermined in the prenatal period, which depends primarily on the psychological state (mood) of the mother. Confucius was aware of this fact as early as the 6th century BC. Moreover, Aristotle dealt with the issue regarding the beginning of life (4th century BC.) followed by St. Thomas Aquinas in the 13th century. What is surprising is the extent to which their views correspond to our current knowledge. Of course, it depends on our point of view, whether we approach solving these issues in terms of philosophy, law, medicine, psychology or theology.

The author also deals with some of the modern issues associated with the current crisis of the family, as is the trend of more “singles”, falling marriage rates, the promiscuous behaviour of couples out of wedlock, denial of paternity, low birth rate, induced abortions, irresponsibility and lack of appropriate identification patterns in the family, and so forth. It draws attention to some of the possibilities and capacities of reproductive medicine, such as cryopreservation of sperm, oocytes and embryos, spare gestation, issues related to genetic engineering and consulting, gender selection and the like.

Key words: *prenatal and perinatal psychology; prenatal communication between mother and child and between partners; current crisis of the family; competence of reproductive medicine*

Importance of family, father and mother in early childhood

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Motto:

“The World is my bosom. The bosom of my mother was my real world.”
Ronald Laing

A large part of the suffering in the world has its origins in the prenatal experiences of infants. These experiences affect them for the rest of their lives – especially when developed in an

atmosphere of conflict and trauma, as well as intense and constant stress and anxiety. Therefore, it is very important to inform prospective parents regarding information in

the field of prenatal psychology and medicine, in order to expand their horizons.

The contact of parents with the child before its birth is very important in order that child does not feel lonely as it develops, and it feels that there is a mother, a father, siblings and extended family and friends, who will help it face the discomfort and tension. We all know that we feel better when we do not have to face the adverse circumstances of life alone. It means a lot to each of us to feel the closeness of another person and to hear words of support and encouragement. A child in its mother's womb experiences similar feelings and later these are the basis of its life energy or weakness. Important research has shown that the consistent and correct behaviour of the parents in a suitable environment can bring positive results to the child and its family. For its growth and development, a child has a need for love, friendliness, understanding and the presence of the parents. These elements cannot be replaced in the child's life. If we recognize that life does not start at the moment of birth, but rather at the moment of conception, it no longer creates a problem to identify with the idea that parents should be able to accept their child from the very beginning of the pregnancy, to pay attention to their child, to get to know it and give it space and support, which is needed for its healthy growth and development.

A child rejected by their parents in the early days of its life goes on living with a strong feeling of emptiness in the depths of its consciousness. This is often manifested later in problematic relationships and poor performance at school, despite the fact that their intelligence is at the same level as their peers. During puberty, these problems only deepen, which can later lead to alcoholism, drug problems and anti-social behaviour, a thing which only demonstrates their dissatisfaction with their own lives. Such people may also have a suicidal tendency in extreme situations. In other cases, these people that were rejected by their own parents, can show no desire for anyone or anything. Actually, people will not even approach them. They may also become very strong and extremely jealous and easily lose control over their behaviour. They hate themselves for the feelings they have. These are often pathologies that have their roots in their initial rejection by their own parents. It's

a major trauma which may persist even if the parents, after the initial rejection of the child, accept their child with love after its birth. By contrast, people who have been given love from the very beginning of their existence can cope with stress and frustration comparably better when they encounter it in their own lives.

From the 13th week of pregnancy (and even more from the 16th and the 17th) a prenatal child manifests its strengths and personality traits, which can also be seen after its birth. The child is constantly more sensitive, communicative, intelligent and sociable, which is especially evident in its reactions.

A child's brain development depends on the interaction between genes and experience. The first three years are crucial for the brain structure. Brain development is not linear as some periods are more important for the acquisition of their brain capacity. During the first three years of life, the child's brain is twice as active as the brain of an adult. It is not possible to separate the mind from the spirit of a child, that's why we consider and perceive the child inside the mother's body in a universal way. We know that an individual's mental state affects physical health. It is not an insignificant fact that during pregnancy, everything the child's mother experiences, her child also experiences with her. Her psyche is highly influenced by the child in her womb. She makes a direct impact during the process of the creation of the child. There is also a clear influence from the father, who contributes his time in an attempt to ease his pregnant partner. Every child needs its mother and father in order to be able to develop fully. Both before and after birth, body contact with the father is very important, since a child can receive its energy through his touch. Through physical contact with the parents, the child feels respected as it receives from them the strength and energy it needs to live. The child is very satisfied when it feels that it is accepted, loved and understood by its parents. This allows it in the future to be himself or herself and to manifest their own essence. The child appreciates the fact, that through the physical touch of its parents they gain a sense of protection and experiences the feeling of security. During pregnancy, parents often find that it is enough just to put a hand

on the mother's tummy and the child calms down. It was discovered that infants also tend to follow the body zone where parents touch themselves. The touch is one of the child's first senses to develop and it provides the child most of the information from the outside world. It is also common that if parents tend to make contact with their child at a specific time, it also lets them know about itself at that time, especially in the third trimester of pregnancy. A prenatal child inherently craves for communication and play with its parents and shows this very early in life. It is very important that the father is also actively involved in these interactions. Sometimes, especially when playing games with the child, the child also reflects its emotions such as happiness, joy, strength, love, kindness, peace, but also anger, misery, sadness.

The prenatal child is a very sensitive being. During the nine months of pregnancy, the child not only receives its first experience, but also bears the first trauma and stress, which, if not eliminated, may cause discomfort and distress to the infant in the future. Children born in unhappy marriages are generally more timid. As shown in the following example, the stress of a pregnant mother can have fatal consequences on her baby. A 17 year old healthy girl gave birth to a healthy baby. Her pregnancy was without health problems. Twenty hours later, however, the child began to vomit blood, and died suddenly an hour later. It turned out that during pregnancy, the mother lived with extreme stress and anxiety – especially in the last trimester of her pregnancy. Forced by her parents to marry the child's father, she lived with an alcoholic who frequently beat her. So she returned to live with her parents, but her husband also often went there to make a scene until he was arrested by the police. The cause of the child's death were diagnosed as three stomach ulcers.

As previously mentioned, the child is closely linked to the emotional state of mind of the mother. The external environment highly influences the overall development of the fetus. We know from experience that a pregnant woman, who is in a busy environment, often experiences intense movements of the child in utero. However, when a woman changes the environment and is already in a quieter place, the child will also calm down.

Trauma in pregnancy affects the baby's health. Research shows that in children, whose mothers during the third trimester of pregnancy experienced stress, are in up to 76% diagnosed with syndromes of neurotic behaviour. Stress during the third trimester may lead to disorders of the nervous system of the fetus, especially to hyperactivity. Stress also causes low birth weight of children and they often suffer from eating and digestive disorders.

Another interesting research is into poor maternal nutrition, particularly in the early months of pregnancy, which indirectly causes obesity in the adult life of the child. The brain – the control centre of nutrition – in such people is actually programmed for the need to eat more than necessary. Pregnancies are the very first days that parents spend with their children. Today, there are great opportunities for prospective parents due to so-called "prenatal education programs". Children of parents who have received this type of training generally show (after birth) a greater interest in the outside world and they have a better ability to take care of themselves. They also demonstrate greater emotional stability, are more able to forge new relationships, and they are more communicative, have better motor proficiency, have better memory and are smarter. Another advantage of these programmes is that the interaction between the partners which brings them closer together. As the practice shows, systematic prenatal stimulation is very beneficial for the maturation of the nervous system of the prenatal child, and it is also a great opportunity for the parents to communicate with their child. This stimulation helps the child to grow and be shaped in a harmonious peaceful and serene way. There are other ways to stimulate a prenatal child. The most common forms of stimulation are; auditory, tactile and visual. Each of these types of stimulation has a positive effect on the physical, motor and social development of the child and also on its integration into the family. Children who have been stimulated during pregnancy, according to research, are more sensitive to visual and auditory sensations, have more motor proficiency, have greater capacity in orientation, and are more responsive by the second day after birth. These children, at the age of 18 months, demonstrate

better speech development, better visual-motor coordination, as well as an increased ability to solve problems. They also have less behavioural impairments.

There has been research on women and their children, who sang the same song to their children every day of their pregnancy. These children after birth, as opposed to children whose mothers during pregnancy did not sing songs, clearly preferred their family's melody, and also were better able to perceive other songs. Singing during pregnancy (or any music), is an excellent way to establish a relationship with the prenatal child and to create a harmonious triangle; involving the mother, father and child. The child in its mother's womb clearly recognizes the voices of both parents, listens to them carefully and adjusts according to them.

Another very beneficial concept for everyone involved is also the so called "non-verbal tactile communication". A woman sensitive to the movements of her prenatal

child changes her positions and abdominal tension, in an attempt to harmonize her behaviour with the behaviour of her child. The child has the opportunity to press against the hands of its mother and father, which develops the relationship and affection between them. It is also very important to continue with this intimate physical contact after birth as close physical intimacy with the body of the child and its loved one gives it a great sense of security. If the child is afraid, does not feel well or is angry, then nuzzling and touching by a loved one calms the child down and returns its lost balance.

It is quite necessary that the parents open their hearts and souls as much as possible to their children, without fear and anxiety, transmitting their nature and love and therefore being a true relationship model for them. They help children realize the goals of their lives, for which they were born to achieve.

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Mentalizing as complex empathy in interpersonal communication

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Abstract

Secure attachment is the best breeding ground to develop the mentalizing capacity and seems to be an important factor of resilience. It evolves from a positive relational experience with key attachment figures, who also show these characteristics which are manifested in their sensitive nursing and relationship behaviour. It is believed that the knowledge of the attachment and mentalizing concept is crucial in prevention and treatment of psychiatric disorders, including interruption of their transmission through generations.

Key words: *secure attachment; sensitive mother; mentalizing; psycho-therapy; trans-generational transmission; prevention*

Neurodevelopmental aspects of prenatal child's life

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Abstract

The prenatal phase of life is a critical period for brain development. It is a crucial period for the formation of structural and functional integrity of the brain with the combination of various factors in the unique environment of the uterus. It is a period of manifold interactions that are essential biological conditions for the continuous development of the human brain and it is also a particularly vulnerable period for the development of potential risk predispositions. Several findings suggest that the formation of the human mind starts as early as the prenatal period.

Key words: *prenatal period; development; brain; mind*

Restoring the relationship between biological parents of children placed in foster care

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Abstract

The lecture presented the results of my own dissertation paper, which aim was to determine the extent of emotional frustration, respectively deprivation among children living in orphanages and foster families. The dissertation thesis pointed out the importance of the developmental phases of life and their influence on the formation of the child's personality. It emphasized the impact of a risky environment on the child's behavior, which often results in exclusion of the child from the biological family and subsequent placement in a foster home. The paper clarified the causes of exclusion of children from their biological families, behavior of the parents of excluded children and the social impact of placing the child in a foster home. The dissertation research was conducted in foster home colleges, in foster homes with a family style education and in foster families. In its implementation, we used a quantitative questionnaire form and Fedor-Freybergh's self-assessment scale of deprivation. Based on the processing of the results of the findings in 150 respondents, we designed specific options possibilities of regarding prevention of the emotional frustration among children living in foster homes.

Key words: *frustration; deprivation; child; foster home; family; redevelopment*

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How can health professionals promote strong and loving bonds in the family?

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Abstract

The contribution at the Freyberghs Days Conference focused on the relationships of prenatal, nascent and newborn baby in the space between mother and father, in the medical reality space of the contemporary society. The factors, by promoting of bio-psycho-social-spiritual-sexual sources of bonding and following attachment, are connoted in relation on the ability of carers to treat their emotional sources. As neuroscientists and psychologists, including Peter Fedor-Freybergh, have from the beginning of the second half of the last century described, the parents' ability to fall in love with their children and vice versa shortly after the birth is the cornerstone of all relationships, promotes tolerance and the desire to stay in this relationship. Emotional attunement, the highest hormone level of a mother and her child during the childbirth are at this moment unique and unrepeatable. Birthing institutions have ingrained routine procedures which are based on separate care of children and mothers. This care provides security based on untreated fear of care providers, rather than safety for the care recipient - a new family. The system (some individuals constituting this system) has decide to ignore parental arms at birth. The repeated medical researches and empirical experience have documented that the safety can only be found in unconditional love of parents, especially of a mother. The ability to treat families as units, including the search for safety in their own uncertainties, which should be carefully treated by health professionals by currently completely lacking space for support and supervisions, is a healthy image of healthy medics.

Key words: *prenatal baby; nascent baby; newborn baby; mother; father; health service; bonding; attachment; love; security; certainty; support; supervision*

Diversification of Czech obstetrics

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Abstract

We are members of the EU. The EU legislation has greater legal force than the Czech one. It includes Convention of Biomedicine and Charter of Human Rights and Freedoms. In the area of obstetrics, not all workplaces respect the European legislation. We respect Convention on Biomedicine: not benefit, but the will of the patient is the doctor's supreme command? Do we feel as advisers and helpers of a pregnant woman and an expectant mother, or those educated and clever who know what is the best for her, and she does the best when obeys? Can we reflect psychosocial changes in obstetrics which are common to the west of our borders? The topic of pregnancy concerns maternity hospitals only marginally. The main issue: the woman can

choose an outpatient gynaecologist, but a midwife not yet. Change is on the way. Only after discharging herself against medical advice may she refuse the recommended procedure, or vice versa, may she choose this procedure, which is not reimbursable, as an above-standard service (oh the Constitutional Court!). The Czech population of pregnant women has in increasing rate the knowledge about the world trends in obstetrics, and they are not willing to settle for the offered traditional medical management of childbirth. Therefore it is necessary to diversify our obstetrics and to enable every woman to have a labour according her wishes. In the future, our unified obstetrics is no longer sufficient. In most Czech textbooks on obstetrics, the medical management of labour is the only alternative. It is the part of the Recommended Procedure of the Section on Perinatal Medicine of ČGPS (Czech Gynaecological and Obstetrical Society). Most women still adopt an attitude: “Do with me what you want, I wish only it is over.” Many of our obstetricians feel safe in this system and they can hardly imagine any changes. Natural childbirth in maternity hospital has 10 simple rules. The number of women who require this type of delivery is increasing. If any complications arise, the female clients understand that it is necessary to pass to the classical medical procedures. It is the only alternative so far how to discourage women from the risky home birth which is still considered to be dangerous in our conditions. Our obstetrical departments still take a cautious approach to this initiative. Outpatient delivery is not the problem of obstetrics, rather than neonatology. From the economic point of view, it is currently more advantageous in the system of DRG. Birth houses are a common part of the obstetric system in many EU countries. Maintaining the safe conditions, a birth house should not be an obstetric problem even in our country. The women choose a home birth not on the first place, but after the experiences with our standard obstetrics (artificial rupture of membranes, oxytocin, episiotomy, unexplained surgery, Kristeller maneuver, etc.) or because of primary fear of an ordered obstetrics. It is only the matter of time when the women labouring at home are not depended on undeclared work of midwives and Emergency and Rescue Service, and when the state have to guarantee them a professional help. At present days, programmed childbirth is hopefully a trouble-free, marginal part of our obstetrics. Provided the meeting of conditions and induction scheme, it is highly efficient. Caesarean section is not provided on mere unjustified request. The pregnant woman has always some reason – especially psychological – for refusing the vaginal delivery: case history, fear of pain, worries about the fate of a baby when hypoxia suddenly arises, vaginal extraction surgery, alteration of subsequent *vita sexualis*, late effects, especially disorders of pelvic stability and incontinence. What are the complications of Caesarean section and subsequent pregnancy considering the birthrate of Czech women? This problem has not to be solved any more west of our borders.

Key words: *diversification; pregnancy; obstetrics; medical management of labour; natural labour in hospital; programmed labour; Caesarean section because of psychological indication*

Obstetrics in the “old regime”, and mainly the management of physiological birth, as well as all human activities during the socialism, was very easy because of central management by the highest authority, that even in obstetrics was not often determined only by professional qualities of the person, rather than by their party affiliation. Until the change of regime in 1989, several generations of our obstetricians including myself learnt from the textbook *Obstetrics* by Kotásek where in the chapter *Medical Management of Labour* is written on the page 166: “Operating procedure in the delivery room must follow certain immutable

rules to provide from the very beginning the best possible conditions for its further progress” (Kotásek 1972). Therefore it means that the obstetrician made all decisions in the management of labour, the midwife performed his commands and orders, and the expectant mother did her best when obeyed so everything could turned out the best. Her feelings, wishes, anxieties and the whole psychology of her personality were not taken into consideration. This system of ruled safe delivery was called medical management of birth. The doctor managed the delivery and he knew what was the best for others.

The situation in the whole society changed 25 years ago. We have a new system and learn more or less successfully the rules of liberal society, and the changes in obstetric thinking touch the obstetric practice and penetrate both easily and with gritted teeth into it. Together with the freedom of access to information and removing any censorship, obstetricians and midwives as well as the whole society get to the information about obstetrics, which are on the scale from the medicine based on proofs to the total nonsense from psychopathic individuals on the Internet. Well, let's try to choose from this – what to do in obstetrics, during the childbirth and postpartum period to meet the requirements of *lege artis* procedures, to satisfy the desires even of the most agile midwives, and fulfill the wishes of pregnant women, labouring women and women in childbed. And not only theirs but also the wishes of the child's father and other relatives who consider themselves as the part of pregnancy.

It is clear that the concept of medical management of childbirth is not enough any more. If we tried to apply it, at least they would laugh at us, in the worst case we would be the object of concerns. New views on managing of physiological labour are penetrating even to our professional periodicals. In our post-revolutionary textbooks, e.g. Zwinger et al. (2004), Roztočil et al. (2008) or Hájek et al. (2014), in the chapters of physiological pregnancy and delivery can be found the mentions of other possibilities how to manage the delivery, and therefore the obstetrics diversify. It is often very difficult to be knowledgeable in the labour diversification. Of course, the easiest way is to follow a recommended procedure of managing the delivery and not deflect from it. But nowadays it is not possible. The doctor – obstetrician is no longer the absolute master over the events in the delivery room. A major factor in determining the strategy of childbirth managing is not the doctor nor midwife, rather than mother-to-be. Since 2004 we are the members of the EU with the rich legislation which takes precedence over our laws. Laws concerning the obstetrics are contained in the Convention on Biomedicine and the Charter of Human Rights and Freedoms which are implemented into our legal system and they are superior to it. There is not enough space

to explain in detail the influence of both these laws on our obstetrics, however, the main motto is: “Not the profit of a client but her wish is the highest order for the obstetrician.” This simple quotation completely changes the situation for both the obstetrician and midwife in their care for the pregnant woman, labouring mother and woman in childbed. We are not to decide what is good for a woman in childbed, how she should behave during pregnancy, how to deliver her baby and what she has to do in postpartum period. She herself decides about these issues. Obstetrics staff both doctors and midwives are no longer those educated and wise who know what is the best for a woman and she does the best when obeys, we are educated people who listen to her opinions, and advise her with our best knowledge and conscience to deal with these periods, not only in the area of medicine (we are good at it), but also in the psychological area (we are less successful) and social (we are complete amateurs there).

During the total regime, thanks to our colleagues from Znojmo, we already started to discover the diversification in obstetrics, which many of us found unthinkable and perverse. What was the controversy surrounding the father at birth or water birth. Nowadays, the father at birth is no longer a curiosity, it is rather a wonder when he is missing. I find myself the water birth very agreeable, however, this labour option has no significant extension. We are probably not fish.

The population of expecting mothers can be divided into two groups. In the first group, there are women who, getting pregnant, are glad when somebody guides them through the pregnancy, childbirth and puerperium with the least possible complications and, if possible, in a pleasant way. They are not active and still saying: “You know the best what is good for me.” On the other hand are so-called “active mothers” who think deeply about their pregnancy, labour and postpartum period, get information from various sources, write birth plans and are convinced that they have the clear recipe for their own delivery that is the most suitable for them. The first have been decreasing, the latter increasing in number.

Therefore the providers of obstetric care are in these days confronted with various wishes of pregnant woman, which are often hardly understandable for them (lotus birth)

and sometimes are on the border with an illegal activity (planned assistance in birth at home, placenta consumers, supporters of “placentophagy”). Some wishes of pregnant women are for the certain part of obstetric staff unacceptable. How can a pregnant woman wish Caesarean section without our approval and agreement?

Do we therefore respect the European legislation mentioned above? ÚZIS (Institute of Health Information and Statistics of the Czech Republic) is not able to evaluate what approach outpatient gynaecologists as well as our 94 maternity hospitals and those who share the care for the woman in childbed take to pregnant women, labouring mothers and women in childbed. Certainly a colourful spectrum of maternity facilities exists, from the workplaces highly responsive to the women wishes to the workplaces which are absolutely restrictive and follow the orthodox recommended methods, and the space for the discussion with an expectant mother is significantly restricted. Their argument is on the one hand the fear from the obstetric failure with subsequent potential complaints and legal actions, on the other hand the conviction of their own unmistakable and unchanging truth.

What does it mean the term diversification of the Czech obstetrics, and how this obstetrics will look like? This is obviously crystal ball reading that I cannot. It is hardly to say if the women in 5, 10 or 15 years eat mixed placentas or give birth to their babies at home in winter and in the forest in summer. However, in the Czech obstetrics already exists the differentiation of obstetrical care. In the area of obstetrics it is the question who will the prenatal care provide. The obstetrician, midwife or somebody else? Only minimum of pregnant women will probably in the future refuse the prenatal care referring to the fact that pregnancy is a physiological process and does not require a doctor or a midwife. It is commonly known that our prenatal care is extremely hypotrophic, and nowhere in the world it is cared about pregnant women in such an extent as in our country. It is certainly possible to have a discussion on the point of all the clinic, laboratory and instrumental methods during pregnancy. It is sure that midwives offer much easier and for women more acceptable system. They include also the

labour preparation, various type of exercises and swimming, therefore the prenatal care is for women more attractive and pleasing.

Not later than in the third trimester, women start to think about where and how to deliver their child. The number of women who deliver their child according to the area in which they belong has been also decreasing, and they respect the recommendation of their outpatient gynaecologist. It is rather he who gives her several options. Recent psychological studies in Prague Psychology Department of the Faculty of Arts, Charles University shows that women with physiological pregnancy evaluate the care in small hospitals better than in big university ones. The reasons have psychological, rather than medical character. Logically, in small hospitals women receive more care then in overloaded university centres. Well, and how to deliver a child? These active women think about the issue in their birth plans. Very often are these plans large elaborates which present for the reader with professional obstetrical education the source of inexhaustible information of frequently very peculiar character. However, from the practice it is known that the birth plan written by primipara is the idea of a client who often changes very quickly during the first strong uterine contractions. Birth plans describes clearly what the woman's wishes during the delivery are, and how she imagines the process of childbirth. These points of birth plan are everything but medical management of delivery.

So what is the diversification of Czech obstetrics? The number of women wishing medical management of labour (i.e. safety, continuous monitoring by both the obstetrician and midwife, respect for routine obstetrical procedures such as strengthening of uterine contractions using oxytocin, rupture at 3–4 cm, routine episiotomy of primiparas, immediate neonatal examination by a pediatrician) has been slowly decreasing in favour of those who have a clear image about the delivery of their offspring. On one side there are women who want to give birth as naturally as possible, on the other hand those who wish the quick termination of pregnancy by intended Caesarean section. The number of women who want natural delivery at maternity hospital is increasing. It is quite easy to fulfill those 10 rules of

natural birth at maternity hospital (Babyweb.cz 2014). They are becoming the part of our textbooks on obstetrics (Roztočil et al. 2008, Hájek et al. 2014). The number of women who require this type of delivery is increasing. If any obstetrical complications arise, these female clients understand that it is necessary to pass to the classical medical procedures. It is the only alternative so far how to discourage women from the risky home birth which is still considered to be dangerous in our conditions. After the initial restraint, there are more and more obstetrical workplaces where both doctors and midwives follow these instructions.

Other alternative may be an outpatient delivery when a woman stay in hospital just for the shortest possible period of time. It may be for two-hour early postnatal period to 24 hours when the woman gets some sleep in maternity hospital and the following day leaves for home. This issue is no of obstetrical nature, when most women after physiological delivery are really able to go home, but of neonatology, when the Czech Neonatology Society recommends to women the 72-hour hospitalization not because of them but because of their newborn baby care. From a purely economic point of view, the outpatient delivery is for obstetricians beneficial because in DRG system is evaluated the labour, not the period of hospitalization.

West of our borders, the birth place could be a birth house. In our existing conditions, the realisation of the labour management only by midwives in a birth house is significantly problematic based on the history of Center of Active Birth (CAP), Bulovka in Prague. However, if meeting the safety conditions valid for our obstetrics, especially the 15-minute accessibility of the standard maternity facility, and reaching the rational factual and staff equipment of a birth house and the agreement on cooperation with a standard maternity hospital, a birth house should not be a problem in our conditions. I would not like being an economist in a birth house, and I cannot imagine its financial operation in our conditions.

A home birth is a very popular topic in the media. Despite likely increasing number of women who choose this type of delivery, it is still about several hundreds cases. The exact number cannot be determined. It is quite

a marginal area of our obstetrics so far. The women labouring at home probably does not want it on the first place. They choose it after the experience with our standard active obstetrics or because of the fear from the ordered obstetrics. Despite of this, it is quite queer that the issue of birth at home causes such a professional, amateur and media sensation. West and south from our borders, this issue is regarded in most countries as media dull, not controversial, and quite non problematic area of obstetrics. In our country, scrambles for a home birth have got on the level of personal conflicts between the female apostles of home birth, who are represented by some very well known midwives, and primarily bad spirited obstetricians. Hungarian case Ternovski and two legal actions against the Czech Republic at the Strasbourg Court for human rights maybe put more light into this issue. If we are not able to reach the agreement, we must be adjudicated by the European Union. I am convinced that it is only the matter of time when women labouring at home will not be depended on undeclared work of midwives and Emergency and Rescue Service, and when the state will have to guarantee them a professional help (Měchurová 2013).

Obstetricians and midwives, and not only them, are again and again surprised by new initiatives of pregnant women and their images of labour management. Lotos birth alias not interrupting of umbilical cord with the following postnatal coexistence of placenta and newborn baby find obstetricians, and mainly paediatricians hard to swallow. The paediatrician can hardly imagine that besides a baby in the cot is also a retained placenta. I met the case of placentophagy already during the total regime. Back then the patient brought with her a blender of ETA brand, cut the umbilical cord from the retained placenta, mixed the placenta and drank it. I do not know if it was flavoured. Nowadays supporters of "placentophagy" have the more sophisticated methods and they make from the placenta small pockets, which are made in a company, already existing in our country. They eat the pockets not only by themselves but also in the family circle. These activities are not of medical issue but rather the legal one. The law on specific medical services and the law on funeral services forbid us, because of hygienic and epidemiologic reasons, to let

the parts of organs which have to be destroyed in special mode. As we can hardly imagine that a diabetic take from the hospital their amputated leg or a woman her removed uterus, it is impossible from legislative reasons take from the maternity hospital placentas. On the other hand, our new problematic Civil Code allows it under the protection of a personality. Therefore it is obvious that the attitude of obstetricians in this issue has not clear legislative support.

And what other options prepare for us these alternative women? I have already heard about the delivery into the stream with running water which should clean not only the woman but also her nascent fetus, which slowly approaching the birth in the nature in our meadows and groves. Will it be the news? It is said that some of our grandmothers also gave birth during the work on the field by the meadow. And then can women deliver symbolically too. For example under the Zizka linden or at Christmas in Bethlehem. The borders of labouring woman's wishes are, and in the future certainly be, endless.

On the other hand, there are women who strictly refuse vaginal birth and wish for the intended termination of pregnancy by Caesarean section in full term. Incorrectly is this delivery called Caesarean section on request. The woman has always some psychological reason to refuse vaginal birth. Psychologically, this situation is characterised by anxiety. The pregnant woman has mainly fear of the delivery based on the case history of her previous childbirth (prolonged pain-

ful labour, extraction operation, hypoxic newborn baby, etc.), she can have an excessive fear of labour pain, fear of the child's fate when unexpected hypoxia arises, or from the late effects of vaginal birth. They includes the alterations of subsequent sexual life and late effects of vaginal birth, especially disorders of pelvic stability and incontinence. The opponents of Caesarean section because of the psychological indication often argue against the complications of Caesarean section and subsequent pregnancy. It was repeatedly proved that intended Caesarean section has the same number of complications as vaginal birth and far less late effects. Considering the birthrate of Czech women (Babyweb.cz 2014, Hájek et al. 2014), the frequency of scar dehiscence after the Caesarean section, uterine ruptures, increta and percreta placentas is really casuistic. The problem of increasing frequency of Caesarean sections, including the Caesarean based on the case history and psychological indication has not to be solved west from our borders any more. This is also the case of some of our big maternity hospitals (Roztočil 2004). The discussed programmed childbirth has already become a common method for the termination pregnancy without the medical indication. Its frequency is not high and does not lead to passionate discussions (Roztočil et al. 1997).

Therefore it is obvious that we cannot avoid – whether we want, or not – the diversification of our obstetrics, and for both obstetricians and midwives will be an advantage to prepare for this professionally as well as mentally.

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The right to informed choice: maternal (parental) autonomy and its limits

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Abstract

The principle of patient autonomy is in today's concept a driving force of medical ethics. According to Beauchamp and Childress, the main aspects of autonomy are "freedom, i.e. independence of the surrounding factors and control, and the capacity for volitional action in agreement with the chosen plan". Informed consent is in contemporary ethics of medical care an implementing tool of patient autonomy. The issue of "informed autonomy" is projected into seemingly unrelated topics such as abortion and so called home births. The right to self-determination, i.e. "patient", here maternal/parental autonomy, is in this case limited by the rights of a child that is not able to express its wishes yet. In the legislation of most western countries is in relation to abortions used "for choice" strategy based on the belief that "nobody has a right to interfere in woman's choice nor her ideas about the moment from which the person's life becomes human" (Haškovcová 2002). In this context, the Czech legislation on abortions belongs to the most liberal ones, and strictly speaking, the woman's independent decision is not in principle up to 12th week of her pregnancy limited. Also in our society there is a majority opinion that the woman herself has the right to decide whether the artificial termination of her pregnancy should be provided. However, the situation changes dramatically in the moment of so called home birth. How it is so that up to 12th week of pregnancy has a mother full right to decide about being and not being of her offspring, and several months later she cannot decide about the way of its birth? The key to understanding of this ambivalence lays in deep-rooted paternalistic paradigm. The woman autonomous decision for abortion is considered as "right" because it has medico-centripetal tendency – the woman submits herself to the physician care. The woman autonomous decision for home birth is "wrong" because it has medico-centrifugal tendency – the woman escapes from the visual field of medical influence and care. This essay is not about the contemporary practice critic of attitude to abortions nor the apology of home birth. It is about the balanced perception of women's (hence parents') autonomy in the situation at the beginning of pregnancy as well as its end. The right way to balanced autonomy is the right to informed choice, both in the questions of abortions and home births.

Key words: *autonomy; expectant mother; abortion; home birth*

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Community care in perinatal period

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Abstract

The perinatal period is characterized by physiological changes in the body of a woman, which represent new conditions for her and require adaptation. Pregnancy is a physiological period in which a new organism develops in the mother's womb and the woman is preparing for a new role – the role of a mother. Specific health care in perinatal period is ensured by gynecologists and obstetricians in cooperation with midwives and community nurses. Their work in prenatal and postnatal periods lies in the care of pregnant women. It is the quality of prenatal care which can greatly influence the course of childbirth and the postpartum period of a woman. The aim of the paper is to present ways of providing community-based perinatal care in the former Czechoslovakia and in selected European countries.

Key words: *perinatal period; community care; community nurse; midwife; family; child*

Prenatal life from the perspective of ethics

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Abstract

The author in the first part of the article describes how prenatal life is viewed by professions such as biologist, philosopher, theologian, jurist and politician. It is clear, however, that these various views always describe the problem of a narrow perspective of these profession's fields. The author sees two key issues – respect for human dignity and when, in fact, human life begins. The author presents the historical development of the concept of the “person”, important philosophical theories, including the moral philosophy of Immanuel Kant. In the other part, the author deals with the question when real human life begins, as well as aspects of prenatal development from the perspective of human genetics, immunology and embryology. He believes that entire human life is one continuous process, from the moment of fertilization until death, and according to the author this entitles humans to protection from conception to death.

Key words: *prenatal life; ethics; concept of the person; human dignity*

Nowadays, prenatal human life is often perceived as a “problem”. Biologists, philosophers (including theologians), as well as politicians and lawyers express their ideas about it. Let’s have a look at what is their view on this set of questions by the certain groups.

Biologists, as well as physicians and geneticists, comment on this topic the most often. At first glance, just these experts seem to have the right to define this issue most of all.

However, the crucial question is whether the definition of a human being is based on biology, or whether this stated “right” by biologists is not too indebted to materialistic and reductionist thinking. One cannot claim that biology can express everything “essential” about a human being. Moreover, it would be first necessary to define the term “nature”, and this is a task for philosophy, not biology. We cannot reduce the wholeness of a human being to life manifestations. Those are just its parts. Biology never answers the question WHO is actually a human being. This issue goes far beyond the possibilities of empirical (natural) science. It is necessary to note that only so-called “genetic humanity” is not and cannot be a criterion of human individuality (ironically, after all, the tumour cells are “human”). A HUMAN BEING is, after all, more than the sum of personal genes! It can be said that we cannot explain the higher principles of life “from the bottom” (using genetics, biology).

Today, philosophy in this field significantly lags behind the knowledge of natural science. Philosophy believes that individual life starts somewhere in the course of human development. The entire time it operates within a “functional” state, shape, size and abilities, etc. These are, of course, important characteristics of a living organism, but they are also just a manifestation of its rightful development which is pre-programmed and which requires appropriate external conditions and support.

Theology today, as is the case of philosophy, also lags behind in trying to capture the combination of both physical and spiritual aspects of human existence (so-called *animation*) in the prenatal period, which is impossible from the view of human recognisability. Theology today continues to especially repeat thomistic conclusions

and possible actions. However, it is indebted to the former, ancient and medieval level of knowledge.

The law in any society always respects political will and attitudes of the society. The law is derived from the ethics of the specific society and not vice versa. The law is at the end of the process. Therefore, we cannot argue those issues that are or are not written into the acts!¹

A politician tries to impact the attitudes of the society however he himself is more created by public opinion and attitudes. He must respect and also represent these attitudes. He never goes “against” them as he wants to be re-elected. There is rarely a very strong personality in the role of politician who withstands the pressure of public expectations. It can be said that we can hear from a politician only what the society thinks and what the society hears back from him as an affirmation of its own “truth” and attitudes.

Here it is necessary to draw attention to the huge and, current prevailing influence of media just to create positions in the society. Yes, in today’s world, especially and foremost, the media are those which “loudly” and explicitly or subliminally create the opinion of the society to certain problem. The media which, and let’s remember this, in essence, is responsible to nobody what and the way how they present the issues. Public opinion is then the “truth”, “something, what is right”, “something, what has to be in this way”, and majority attitude, opinion is then the main and final criterion of the “truth” to any problem!

If we want today to discuss issues of prenatal life and its protection, we must start with two basic questions that are closely related. The first one is the issue of **human dignity** and the other one is the question regarding when an individual human life begins.

Respect for human dignity, which is inviolable, is not dependent on age, health, level of development, or level of consciousness, but rather is due to the fact that human beings are derived from human individuality. This human dignity is preceded by certain legal provisions. This includes implicitly, the principle of untouchability of human bodily existence. Human dignity does not have any specific standards for our behaviour, but rather, it is a basic framework for everything

else. A human being, thus, has dignity for its humanity and there cannot be any legal right graduation to protect life, depending on what kind of human being it is, therefore, it is based on humanity “without adjectives”.

Where do we derive this human dignity from? Today, there are essentially two ways – one is a concept of so called person (“religious” solution), and the other is Kant’s moral philosophy.

The word person, *prosópon* in Greek, *persona* in Latin, originally meant a “mask”. It is necessary to note that the concept of a person is not a biological concept, but it is an ethical, ontological (philosophical), theological, or legal concept. To grant somebody with ontological status of a person means to assign all the moral rights of a human being, including the right to protection and the right not to be killed.

The issue of distinguishing a person from its nature (*natura*) is part of the dogma of the Holy Trinity of the Catholic Church, and represents a relatively complicated theological and philosophical problem and also has a quite difficult interpretation during the present time. The development of conceptualization and definition of a person during the development of Christian philosophy (and subsequently theology) and philosophy, has undergone shifts in meaning.

Tertullian writes about the conception of a human embryo: “*Est homo et qui est futurus*” (meaning, “This is a human being and the one who becomes a human”).

According to Boethius, only humans have an intellectual nature (i.e. Boethius implicitly excludes a human from the concept of person until it is a “wise” being, he thus excludes not only prenatal existence but also quite a long part of the childhood). “A person is an individual substance with a rational nature” (“*Persona est rationalis naturae individual substantia*”). His thoughts (the characteristics of a person is the way of existence) were freely followed also by others, such as Richard from St. Viktor, J. P. Sartre, M. Buber, S. Kierkegaard, F. Nietzsche.

St. Thomas Aquinas held progressive “spiritualization” of a foetus: in an embryo, vegetative soul is present first, then sensitive soul, in the end rational soul (this appears 40 days after conception in men and, 90 days after conception in women), but these are slightly

modified ideas coming from Aristoteles (in his opinion rational soul appears 46 days after conception and from this moment of animation a being becomes an individual).

The philosopher John Lock argues that any person is a moral entity that has responsibility, has a sense of oneself, engages in self-control, and creates relationships, etc. Lock, however, excluded from the right individual status not only embryos and children, but also individuals with dementia, and people in comas, etc.

It can be said that through history two attitudes have been created:

1. A human being **becomes a person** only during its prenatal development or at specific time after the birth = *empirical functionalism, gradualism*. Therefore, whether it deserves protection of a human being, depends on certain criteria. WHEN is it possible to award an individual with a status of a person? During the time of embryo implants itself in the uterus? When the nervous system appears? When there is a heart rate or when the brain develops? When foetal movements start? At the moment of delivery? Twenty-four hours after the birth? After the infant’s first moment when the mother bonds with the child? When we enter into a contact with the neighbourhood? In realization of one’s own existence?
2. An embryo, **from the moment** of conception, is a complete human being = *ontological personalism*, when a person is seen as an act of implementation. Therefore, it cannot be said about a human that it “is”, but rather it is “becoming”. A human, according to this approach, is a person, even if the consciousness has not been fully developed yet. It is impossible to equal human dignity and the developed consciousness, i.e. reason. The human being is a substantiality and subjectivity that pre-dates the existence of case relationships. The dignity of a person is not something that should result from the dependence on other people (e.g. on one’s mother). The human exists if he is alive, and when he is alive, he exists, and if he exists, he exists as a person. Being a human being means to be “automatically”

a person. Therefore, it is about being itself. It means to belong itself, not to be owned, during the beginning of its existence. Life is to be regarded as untouchable from the beginning. It is necessary to see this dynamic, developmental aspect of a person as a human grows to a person, first physically, then mentally, and finally spiritually. But it is able to become a person in its further development) from its very conception, the status of a person cannot be derived from development criteria, i.e. whether the embryo at that moment has or does not have these properties – these do not give a human the status of a person, but rather on the contrary are based on its existence and they are manifestation of its programmed development. Development from the conception to death is an absolute biological continuity!

Another way to grasp the problem is offered by **Immanuel Kant** in his moral philosophy, which expresses the opinion that human is itself the target and the dignity of a human person results from the existence of a moral sense confirmed by categorical imperative and moral obligation resulting from it. A human being as a bearer of moral obligation is removed from the chain of causality and expediency. A person is something that may never become a purpose. Therefore, a human being can never be used as a means! This is Kant's basis for autonomous, based on a human being, it is not transcendental ("religious"), and does not refer to a "higher" authority, etc.

It is, therefore, evident that relative complexity of interpreting the concept of a person, with respect to the historical development of this concept which makes theology in this field rather "ponderous" and for today (especially in relatively secular societies, such as the Czech one) not entirely convincing and sufficiently argumentative. Here, just that Kant's vision of a problem would be more acceptable. To protect and defend the newly created life, we can add one more ethical approach – it is so called prudential personhood, (i.e. "a person of prudence"). In the case of doubt whether the being is a person, it is better to be considered a person and protect it. In other words, unless it is proved that the embryo is or is

not a human being, we should treat it as an individual. Otherwise we are talking on a so called "slippery slope".

The other fundamental question is, **WHEN the formation of an individual human life begins.** A look back to history provides us with quite a wide variety of opinions, as the awareness regarding human reproduction and its prenatal evolution developed (from antiquity to the seventeenth century, it was believed that it was the sperm which contained everything necessary for the formation of an embryo, menstruation is a nutrition, a woman is the passive factor of life formation while a man is the active one). In 1621, Hieronymus Fabricius described the ovaries. In 1627, Regnier de Graf described vesicles as "follicles" with ova, and in 1953 Watson and Crick discovered DNA.

To create a new human life, three components must be (gradually) connected (cooperate): sperm + ovum + uterus. At the moment of fertilization, the first two components are fulfilled. The third is an implantation of a fertilized ovum, which occurs by fourteen days after fertilization.

From the immunological point of view, a new individual arises at the time of a sperm and an ovum fusion, when new, specific surface antigens appear which are detected as foreign by the maternal immune system. The embryo, thus is not a part of maternal organism, conversely, it treats the embryo unfriendly as to a foreign body. Due to a well organized defence, an embryo is not destroyed. The embryo protects itself with a "shield" of follicular cells (resulting from Graafian follicle), which mask the presence of a new, immunologically different individual. Only after the trophoblast has been differentiated, with the ability to nest into the uterine lining and prevent the attack of the mother's immune system, the embryo begins to defence itself. Therefore, it can be concluded that immunologically the new human embryo is not a "part" of a woman's body. This is also necessary to relativize the significantly so called "right" of a woman to decide fully regarding the life of the embryo (as it is a part of herself). But of course, this is a problem far more complicated which cannot be narrowed just by this immunological view (e.g. for an embryo development is needed a uterus, which is a part of a woman's body).

From the genetic point of view, a new individual is created after the fusion of the nuclei of both gametes, and it occurs 24 hours after penetration of the sperm into an ovum. A new, unique genome is created by combining maternal and paternal gametes (with elements of “coincidences”, such as crossing-over, segregation, when a unique genetic individuality arises – a statistical possibility is the rise of 2^{23} combinations of sets of chromosomes in each parent, for the formation of a unique new individual is then option of 2^{46} combinations).

From the embryological point of view, a new individual rises by “reading” of its genetic material formed during fertilization, by transcription of genetic information, which occurs in first to third division of an ovum, during replication of the new, unique genetic make-up of a new individual (formation of blastomere). Maternal mRNA of an ovum during the first and the second day after the fusion of gametes decomposes and is replaced by a new mRNA, already resulting from the transcription of genes of a new individual. Transcription of a zygote genes proceeds therefore from the beginning. The genetic uniqueness is thus accomplished from the very beginning of the existence of a new individual.

Regulatory mechanisms are released during the prenatal and postnatal development, which provide the necessary information for a given stage of development of an individual (gene expression). But it means that a basic set of information is contained in the genome of an individual from the beginning, it does not change, only a rate of its application develops. We can conclude that an embryo is an **autonomous** being (it has its genome), an **autoregulation** being (it governs its development) and an **autogenerative** being (it is able to give a beginning of a new life to its resembling being). The newly formed individual is thus specifically human from the beginning. All human life is a **continuous process**, from the moment of fertilization until death. Therefore, pointing out that the early embryo (earlier philosophers) “has no human features”, “is not sufficiently determined”, “is not formed germ” is therefore

meaningless – it, of course, corresponded to a given level of knowledge. There are no limits when discussing the “hominid evolution” of the embryo. All criteria asserted by us and all attempts to determine the boundary are therefore **purely arbitrary** (e.g. nidation of the fertilized ovum, formation of the brain in twenty-second week, the possibility of independent existence outside the uterus, etc., etc.). It is not just about a purely theoretical problem. The determination of the “boundary” is essentially related to the degree of protection of the embryo, admitted by us (or not admitted, i.e. with possibilities to manipulate the embryo or eventually to destroy it).

It is necessary to find a unifying principle, due to which the existing human being is the same all the time of its existence. It arises at the moment of its fertilization. However, not just biology can answer the question WHEN A HUMAN BEING arises, nevertheless human life arises through fertilization.

Our discussion today regarding the degree of protection of an embryo has implicitly its historical dimension. That is the status and protection of the newborn. The view of a child has significantly changed in the course of human history (focused on Europe), from irresponsible individual in times of antiquity (with a certain degree of that society tolerated infanticide, through breakthrough brought by Christianity (with a statement of the right to life and dignity to each person, from the emperor to the last slave, from a newborn to the elderly). However, the practice was seldom so ideal in medieval Europe, which was time of high rate of child mortality, when individuals were “registered” only around the tenth year of age (usually referred to as the time of confirmation). Today the child’s status, both real and legal, is at such level in our society that would be considered outrageous to people during earlier times. It is clear that the process of recognition of the child’s rights has been evolving into its present form, for example the legal protection of a newborn infant, as well as the process of recognition of the rights of an unborn child (the embryo from the beginning of its existence) will be a long process, a process of uneasy cultivation of relationship of a human being to life.

Notes:

¹ We can show an example of an ancient Rome that this is indeed the case. At that time the infanticides were carried out because the society at that time considered it legitimate under certain circumstances. Concurrently, Romans had developed a legal system, Roman law is even today the name and we constantly draw from it.

Therefore, we can hardly say that the ancient Romans did not live in a legal state although infanticide was legitimized here. Attitudes of the society, its perception of ethics and morality thus precede legislation (also therefore we speak both about the “spirit” of the law, and about the “letter” of the law, when this “spirit” precedes its own diction, the “letter” of the law).

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Ethics of relationship to an unborn child

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The author deals with ethics regarding the relationship to an unborn child involving the theories of care and responsibility. The author focuses on the definition of responsibility by Hans Jonas, differentiation of criminal and moral responsibilities and further responsibility for completed work or for results now and then also in the future. A woman's responsibility is morally based and is future orientated with an uncertain

result. Assuming responsibility is a serious decision which will significantly influence the rest of a woman's life. Therefore, today's society is forgiving towards women who reject responsibility and terminate their pregnancy with an abortion.

The topics of an ethical relationship to an unborn child are occasionally uselessly narrowed only to the problem of abortion. However, even this is usually solved in a

one-sided manner. James Nelson offered as recently as 1992 a better solution for this problem than the traditional conception of human rights and the basic question of ontological determinism as when a human being becomes a human being. He quotes Anne Warren (1989) who basically states that “one skin is a place only for one person with full human rights”. Common solutions for abortion problems escalate the conflict between those discussing this issue and a pregnant woman and her foetus. A prohibition on abortion on this basis makes a woman intending to give birth to children a criminal (Tong 1992). Nelson offers a more effective and less conflictual solution in terms of care.

In modern medical ethics, the concept of care is applied reluctantly, more important publications have appeared only in recent years (Van Hoofs 2006, Leget et al. 2011). The primary reason seems to be the difficulty in grasping the term “care”. Care results from both the willingness and from the ability to care, therefore it is connected with the personality characteristics of the person providing care (Zášková and Mlčák 2009). We do not deal just with philosophical vocabulary. It is also necessary to move around in the psychological arena as well. Furthermore, the ethics of care cannot be built on classical Kantian ethics. The authors of the texts regarding care, correctly refers to the work of Carol Gilligan in his work, “In a Different Voice” (1982), which seems to be a classic work even today as well. Carol Gilligan offered, in addition to Kant’s rational method of moral considering (built on impersonal, rational considering principles of justice, individuality and freedom of choice), a concept of care as the second foundation for both theoretical and practical ethics. Care is not impersonal. It is based on relationship that is not abstract but, results from a particular circumstance, works with emotions and the main theme is dependence and the inequality of the participants. Current ethics of care deals with themes as a problem of symmetry or asymmetry, or recognition and sympathy as the basic concepts regarding the ethics of care (Van Heijst and Leget 2011).

According to the ethics of care, a pregnant woman focuses her care on the developing embryo and eventually the child as well. It is her decision resulting from an evaluation

of her own special situation. In this context, we can persuade women to always adopt a child into their care whenever they become pregnant, and therefore, create religious reasons (moral theological) for care. Women, however, for many years have intentionally undergone abortions and evidently there has always been a degree certain of tolerance to this act among people. (Why would otherwise Hippocrates forbid assistance in abortion in his oath?) During the 20th century, when abortion also became an acceptable execution of health, willingness to recognize all types of women’s reasons for refusal to accept the developing fetus into their care. Apart from arguments such as the indolence of a modern man and the unwillingness to sacrifice anything for another person, let’s try and consider which acceptable arguments lead to the tolerance of abortion.

If a woman takes a child into her care, it is not a temporary task, but rather a life-long obligation. Furthermore, labour will essentially change a woman’s social world. The family expands by one member, and the relationship with child’s father is principally different than with another man. Essential changes also occur within a woman’s body and soul. A woman, after delivery, is simply a different woman than before delivery, this also includes different social situations.

The concept of responsibility which presents some difficulties for modern man, cannot be separated from care. Together with care, the woman assumes responsibility for her child. Theoretically, responsibility may be criminal or moral. In this situation, criminal responsibility shall be put aside, even if it is also in play when a woman breaks a mother’s legal duties in a serious way. We tried to put forth a question, “What is moral responsibility?” Let’s take notice that the base of the word is “respond”, namely not only in Czech but also in other languages (in English responsibility, in German Verantwortung).

Hans Jonas (1997) explains that assuming responsibility means assuming duties. However, the extent and character of the assumed duties are not unambiguously given. A person fulfils them in a creative way. This means to respond to a special situation. In order to fulfil their responsibilities, we have to anticipate a certain power of the individual over the subject or the object of responsibility. It is

impossible to be responsible for something what is absolutely beyond one's control. Because a person too often makes a decision in a situation of uncertainty and then commits an error, responsibility then also brings the possibility of doing something wrong what will be classified as "irresponsible". Maintaining one's responsibility is, therefore, a task that is sometimes easier, and sometimes more difficult, however, always connected with a larger or smaller degree of uncertainty. Nowadays, when there is no agreement on values, no obligatory patterns of behaviour and problem solving, uncertainties connected with responsibility urgently rise. No wonder that a modern man often hesitates to take responsibility.

According to Hans Jonas (1997), we assume responsibility in two ways. We can be responsible for the fact that a certain thing will be done well. As an example, we can use a craftsman that is responsible for a well crafted table, sewn dress, or built house. However, there exist duties directing into the future – responsibility for the way in which the matter I am deciding on or I am preparing, fails in near or distant future, or whether it turns out well. In this case, different political decisions are involved, running a business as well as raising children. A tradesman has an easier position. During an honest endeavour, he learns to make his products properly, and this results in a great deal of uncertainty. A company manager, politician, and parent have a more complicated task. In their decision making process, they do not often have enough information, and therefore, an unforeseen event can reverse honest intentions.. To accept this type of responsibility means to take one's task seriously, to have the necessary scope, consider all possible outcomes and assume the risk that beyond all endeavour the things will not fall out well.

When a woman becomes pregnant, she asks herself the question if she is willing to assume responsibility for the fate of the child. Some women also decide on the degree of responsibility they will take. After which they decide to what extent they will adjust their lives to needs of the developing foetus. Pursuant to this decision, then they devote care to their foetus and also eventually to their baby. As previously mentioned, many women refuse radical interference into their lives

and subsequently undergo an abortion. It is tolerated among others because it is a refusal of a serious, lifelong obligation. It is not a responsibility which ends with a performance of an obligation but rather an action directed at a future responsibility with an uncertain outcome.

Even prior to modern times many people have perceived an impregnation as a result of irresponsible behaviour. This attitude has changed in recent years. Sexuality without a reproductive goal is currently a normal part of a heterosexual relationship. There now exist effective contraceptives whose usage is not demanding. These are used by a responsible couple properly. If these relatively reliable means fail, a woman may rightly refuse to accept the situation of an involuntary pregnancy, as a result of her irresponsibility. This is another reason why the tolerance towards abortion is likely increasing.

Let's try to think about the way of understanding the linguistic base of the word responsibility, which consists of the need of "a response" of a responsible man or in some cases a woman. As previously mentioned, a woman admitting responsibility for her child moves into a situation with many uncertainties, moreover the situation changes daily. Therefore, a woman's responsible behaviour must be really a response to a current situation.

During pregnancy, it is not sure if the child will be born alive, and their features of character and skills cannot yet be predicted. We do not know how they will respond after their birth. Of course, different children need different types of treatment, and a woman must respond to these facts.

From the very beginning, a child develops, and passes through different evolutionary periods. The first great milestone the is delivery. During the next 12–16 years, a child further gains independence. Trapková and Chvála (2004) talk about "the second delivery" – a social one – when children are free from their family and gradually create their own lives. Psychoanalytical theory clearly describes various evolutionary phases (Erikson 1999). A woman must "respond" in "an appropriate" way to the evolutionary phases of her child, react according to her children needs, and not according to her own current mood.

The result is always uncertain. It depends on the parents only to a certain degree. Children form their internal world and their individual reactions. Parents are often helpless in dealing with their errors and mistakes (e.g. in case of an autistic child). In addition, of course, interaction always enters wider surroundings whose influence becomes gradually bigger than the parent's endeavour.

Responsibility for a child is a difficult matter. Mothers act in situations with a lack of information, cope with unexpected changes,

have limited abilities and possibilities. There exist any eligibilities, for future mothers there are neither an organised systematic education nor certified courses. Perhaps it is positive, as a child needs first of all a loving mother, then the next priority – is a well informed mother. However, considering all the circumstances of a mother's responsibility growing up in mother's care, we should better understand why today women postpone the age of their motherhood and why many of them hesitate to be a mother at all.

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Experiencing fatherhood during pregnancy, at birth and shortly after birth

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Abstract

Fatherhood and identification with the father's role is an important period in human life. Especially now, when the society is going through a family crisis, the issue of parenting and fatherhood is very timely. The article gives a summary of information and suggestions about the

importance, characteristics and experiencing paternity in different periods – during pregnancy, at birth and shortly after birth. In the context of reducing the duration of stay in the hospital after birth, there is very little time for parents to get enough information and instructions on the care of their children and to strengthen their parenting skills. The solution might also be an improvement of prenatal training, which should be focused on preparing for childbirth and parenthood and pay more attention not only to the preparation of a pregnant woman, but also to the needs of both of the parents.

Key words: *prenatal preparation; pregnancy; childbirth; postpartum period; fatherhood*

The issue of prenatal psychology

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INTRODUCTION

Prenatal psychology is a very young discipline, which is not yet sufficiently embedded in the public consciousness, both professionally and lay. Many people do not know what to imagine by prenatal psychology.

Previously, people thought that the child developing in the womb lives separately from the rest of the world where its birth will take place. Later it became clear that a prenatal child is not living completely separately, but rather that it responds to the external environment, has developed senses and is even able to remember. This has led to the emergence of the field of prenatal psychology, which focuses on development, human behaviour and experiences before birth. Prenatal psychology is a relatively young field. What happens inside the uterus remained hidden for a long time, and it was only a matter of conjecture until modern technology allowed us to glimpse at the life of a child in the womb. For example, thanks to ultrasounds, we can observe the growth of the child's movements and reactions, without disturbing it. In prenatal psychology, not only child development and behaviours are important, prenatal psychology also looks at the child from a holistic perspective, taking into account biological, psychological and social aspects and the development in all these areas.

Prenatal psychology is a very interesting field and not yet fully understood. I tried to delve into this branch through my thesis.

The goal was to determine how different the communication is with the child before and after birth, whether it is easier for mothers to communicate with a prenatal child or a baby after birth and what means does the mothers and the people around use to communicate with the prenatal child. The research was conducted through structured interviews. Each woman was interviewed twice, once at the end of pregnancy, then shortly after birth. A total of five women were interviewed.

Prenatal psychology

Prenatal psychology is the study of the fetus inside the uterus, as well as its behaviour and mental life. For example, we now know that the fetus in utero is able to use their senses, to remember, to learn and to react to situations and feelings of the mother. Pregnancy can be considered an active dialogue between the mother and child, which can be further extended to a dialogue with both the father's and the mother's psychosocial environment. Ongoing interaction between mother and child during pregnancy has not only a biological nature, but also a psychological and social nature. According to professor Fedor-Freybergh, a prenatal child is not a passive, but rather an active and receptive "passenger in the womb".

Prenatal psychology emphasizes the indivisibility of the primary psychological and physical processes in human life, which creates a continuum from conception to death. Each developmental stage is equally important and all phases are interdependent.

Despite the efforts of this field and its representatives to incorporate awareness of prenatal psychology into the general consciousness, modern societies still consider the beginning of life to be the moment of birth. The prenatal period is underestimated, while the prenatal phase of life is the most important and most crucial period for the entire life of an individual, from the perspective of psychology and physiology. Mental and physical development is affected by human heredity and environment. The genetic material of a child, except for choosing a suitable mating partner, cannot be influenced. On the other hand, we can influence the child's environment where it grows up, even in the prenatal period. The basis of the child's personality and its attitude to the world is already set in the prenatal period, thanks to the either the positive or negative influence of both parents. Optimizing the conditions of prenatal life for every individual may lead to optimizing the entire society. By ensuring appropriate conditions to the prenatal child, we can not only prevent physiological, psychological, but also social pathologies in the future.

Prenatal communication

Prenatal communication offers many advantages, for both the child and the mother. The trust between the child and its parents, and also the trust of parents in their parenting skills emerge through prenatal communication. Parents, who communicate frequently with their child before birth, are much more comprehensive and responsive to the needs of the child after birth. They also show their child their love. Thus, they create the basic feeling of love and trust. Prenatal communications with the child also provides the child with plenty of stimulation and supports its mental and physical development.

An unborn child perceives a great deal of information from its surroundings. Yet in utero, it has developed senses which allow it to perceive sounds, light and touch.

In my research, I learned from mothers about various ways in which they

communicate with their prenatal children. All mothers reported that the most common type of communication is the touch – stroking the belly, then speaking to the child and, singing and music. In most cases, they were also the people around who communicated with the children and received considerable response. Mothers usually react automatically to the communication and behaviors of the child, for example when moving, they touch the place where they feel the movement of the child, thus letting the child know that they know about it and that they are eager the child is all right.

One mother stated strong reactions of the child to her older daughter who, when talking to the child or kissing the belly, causes strong movements of the child in the womb. In her words, both are already well acquainted before birth.

The mother also mentioned communication from the side of her partner, who plays the guitar for the child, and the great-grandmother who always pats her belly and says: "Hello, my girls, granny is here."

One mother said that communication between her and the child runs almost constantly. She often speaks to the child, asking it about its feelings, or tells it what happened to her. When the child shakes a lot, she calms it down with touching. Another mother communicates the same way, and reports a significant calming of the child after verbal communication. According to her, it is as if the child did not want to miss anything and listened carefully. All mothers observed large differences in communication with the child before and after birth. The women see the biggest difference in the feedback, which was much more obvious after the childbirth. The women could observe the child, its reactions, facial expressions, humming and they could respond appropriately. During pregnancy, the feedback was not so visible and the women often did not understand the meaning of the feedback from the prenatal child, whether it expressed feelings of pleasure or displeasure.

Emotions of the mothers and their effect on the fetus

From conception, the mother lives in symbiosis with the child. They are two organisms that are important to each other, interact and transfer information.

The child is relatively soon able to perceive the emotional tuning of the parents, especially the mother's. But the father also has influence and plays an important role in the child's life. He is the one who is involved in the emotional state of the mother, provides her comfort and peace, but he can also be the source of the mother's uncertainty and doubts. The fetus is able to recognize the mother's emotions and it acts accordingly too it.

The relationship of the mother to her unborn child has a significant influence on it, as shown by various studies. The negative psychological states of the mother are one of the most important risk factors for the development of prenatal and early interaction between the mother and the child.

Also, the uterine environment may have a threatening effect on the fetus. The uterus forms the first ecosystem of the child and it is its first world. The child's expectations of the outer world are formed there. It expects the real world to be the same as its "first world". If the child feels loved there, and it was a friendly environment, the expectation is that this will continue after birth. These are the predispositions needed for the child to grow up with an open, extroverted and self-confident personality. If the uterine environment is hostile, it creates a corresponding attitude towards the world. Such a child is predisposed to be suspicious, mistrustful and closed.

Most mothers believed that their prenatal child was able to perceive their emotions and react to them. The mothers stated that if something frightened or scared them, they always calmed the child down and explain to it that nothing was happening and that it did not need to worry about anything. As noted by one mother, when she is experiencing pleasant emotions, for example, when she is looking forward to something like the arrival of her husband from work, the child begins to fidget impatiently, as if it felt that there's something pleasant about to happen. Another mother stated there is a significant response to shouting or when she is worried about her older daughter. The child will make her calm down by its movements and subsequently "lose steam", talk in a quieter tone and soothe the baby that nothing is happening.

The overall attitude towards the pregnancy and the child is also important. I am referring to the issue of wanted and unwanted preg-

nancies. In my research, although it was not always a planned pregnancy, all children were wanted, which I found out thanks particularly to questions about the feelings of the mothers and expectant fathers when the pregnancy was discovered. The most common feelings among mothers were the feelings of surprise, joy and happiness. Some women also reported feelings of uncertainty and fear, especially those whose previous pregnancy ended in failure. In case of an unplanned pregnancy, the mother stated that she was very nervous during the implementation of the pregnancy test, because she hoped that it would be positive. Otherwise, she would have been very disappointed. The general prevailing feelings of the fathers were surprise and joy, and sometimes shock in cases that the joyful news was not expected.

Interview no. 1

Marie is in the fortieth week of pregnancy and is pregnant for the first time. She is twenty-five years old and her highest achieved education is a university degree. She is married.

Marie conceived quite unexpectedly; she and her husband were not trying to have a baby. Yet, when Marie found out that she was pregnant, she was happy. When she first thought she might have been pregnant as she missed her menstrual period for two weeks, she felt very nervous and confused because she did not expect the pregnancy at that moment. To verify her assumptions, she decided to carry out a pregnancy test that she purchased in a pharmacy. During the execution of the test, she was very nervous. She hoped that the test would be positive. Otherwise, she would have been very disappointed. Upon confirmation of pregnancy, she was feeling pleasantly anxious about the new situation she found herself in.

She was looking forward to the announcement of pregnancy to her husband, as they were planning to have children in the future, though not as soon. Her husband was very surprised, even shocked, but eventually he was also very happy. According to Marie's words: "Even though it was an unplanned pregnancy, we accepted it as a gift from God."

The child's gender was not important for them. As her husband, they would like to have

a boy, but when they learned that they were expecting a girl, they were not disappointed. Given that this is the first pregnancy, the gender does not matter. The gender of the child was written by the gynecologist on a piece of paper and kept in an envelope. They opened the envelope together on Christmas Eve as a gift for Christmas.

Marie very often communicates with her child, either consciously or unconsciously. She often strokes her belly and talks to the child. When she goes for a walk, she describes aloud what she sees, and what the weather is like. Sometimes she recognizes that the child does not like her position. The child begins to kick and Marie must sit straight up or go for a walk. Meanwhile, she talks to the child and soothes her, saying she is aware that she does not like her position. Her partner also frequently communicates with the child. He often talks to her, and strokes the mother's belly at the same time. Sometimes he even sings and plays the guitar. In addition, other people communicate with the child, such as Marie's mother, who always says, when they pay a visit, "Hello, my girls!" pats Marie's belly and says "Nan is here". Marie is not sure whether the child responds to the communication, but she explains its movements and shaking as a response.

The movements of the child are an amazing experience for Marie, though sometimes they are painful. She would like to show the movements to others as well, but the child, according to Marie's words, always remains silent and deliberately stays still, although she is trying to provoke her by stroking. Marie perceives the movement of the child as a form of initiation of communication with the child. She often responds to its movements by stroking or words. According to the movements of the child, she is able to recognize when the child is asleep and when awake, although she is not always sure.

Marie believes that the child is able to feel her feelings. Hence, she calms the child down when she gets scared. In this case, she begins to stroke her belly, tells the child that nothing is happening and that it has nothing to fear. Conversely, when Marie looks forward to something, such as the arrival of her husband from work, the child begins to fidget, as if it could feel that there's something nice she impatiently expects to happen.

Marie does not imagine the appearance and the face of the child. The only idea she has is thanks only to the ultrasound, where her child resembled an alien.

Marie expects that communication with the child will change after birth, and that it will be more evident. There will be feedback, enabling the communication to be more intensive, whether it will be crying, curious stares or humming. She is expecting a change in the relationship with the child, but rather than a change it would instead be a deepening of the relationship. What is important for her is the eye contact and observation of the child that makes it easier to recognize the feelings of the child and its needs. She also expects that she will need to limit her activities.

Interview no. 2

Jana is in the fortieth week of pregnancy. She is thirty-five years old, married and has a secondary school education. Jana is pregnant for the third time and is going to give birth for the second time. One pregnancy ended with miscarriage in the first trimester. From the other pregnancy she has a five year old daughter.

Jana planned the pregnancy. After the birth of the first daughter, she and her husband were planning more children. The second pregnancy, however, ended in failure. Later, when they tried again to have a child, Jana managed to get pregnant almost immediately. Therefore, when Jana found out she was pregnant, she was surprised, because she didn't expect, that they would succeed so quickly, but she also felt very happy. Jana experienced these feelings together with her husband. They found she was pregnant together, when Jana, after a missed menstrual period, did a pregnancy test, and they then rejoiced together.

Jana knows the gender of her future child. It is going to be a daughter. Jana is glad to have a second girl, though everyone assumed that the second child would be a boy.

Jana often communicates with the child. In addition to stroking and talking to it, she often plays music. Jana has for this special occasion music for prenatal children, but she also plays classical music, relaxing music, or music that appeals to her. The husband communicates with the child in similar ways as Jana. He speaks to the child or

strokes Jana's belly. The older daughter also communicates with the child. She knows that the baby is in the womb of her mother and often speaks to it while touching the belly and kissing it. The child responds very visibly to this communication. When stroking and talking to it, Jana feels a lot of movement. Most responds, however, are to the older daughter's voice and touch. According to Jana, they are well acquainted already before birth.

The movements of the child are a good sign for Jana, because according to them, she recognizes how the child responds to her and that everything is fine. When the baby moves, Jana feels the need to answer, either verbally or by touch. Sometimes she leaves the movements without response when she feels that the child only needs to change its position. According to the particular motion, Jana realizes if the child is asleep or not. At night the movements are apparently much more frequent and the child is awake. In the morning, on the contrary, the child is asleep and does not move too much, so Jana has problems during CTG screening in the morning, when the child is used to sleeping.

Jana is convinced that her child can sense her feelings that it knows her mood, and that it responds to these feelings. When Jana is upset or worried, or rebukes her daughter, the child reacts with violent movements that, in her words, will make Jana "lose steam". The child makes it clear to Jana that it does not like it when her daughter cries or is upset

and it makes her calm down and speak in a softer tone.

Jana has no idea about the appearance of the child. She expects that the child will be similar to her older daughter.

The biggest change in communication with the child after birth is when Jana expects to see the child. It will be easier for her to identify her feelings and see her reaction. It will be easier for her to know what the child needs or wants. Jana hopes that her relationship with the child after birth will not change. She expects, however, that their relationship will be more predictable. Jana formed a strong attachment to the first daughter after birth and she expects now that it will be similar.

CONCLUSION

Prenatal psychology is a very young and interesting field. It is interesting because a large part of the knowledge remains undiscovered. It is also an interesting field for expectant mothers, which means pregnant women. They often do not know or do not understand what is going on inside them. Prenatal psychology can provide answers to their questions regarding their prenatal child. During my research, I found interest amongst mothers in this field and the information it could bring them and that could improve their relationship with the child.

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Selected ethical issues in perinatology

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In the past decade we can observe an increasing age of women regarding when they decide to be a mother. Some women sometimes even completely reject the pregnancy. Primiparas aged 35 or 40 are not exceptional. Unfortunately, not all of them who decide to hold off the motherhood, are guaranteed to have a smooth pregnancy and a healthy baby. With the increasing age of a woman, fertility decreases and the risk of congenital defects and premature birth increases (Velemínský and Velemínský 2010).

The Czech Republic must deal with the increase in mothers over 35, as also must many other countries in Western Europe (Hamplová 2011). The scientific field dealing with the healthy development of individuals during the last stages of intrauterine foetal development and the first days after the birth is called perinatology. This branch is currently confronted with ethical dilemmas which have a strong influence on the decisions

of obstetricians and neonatologists for any uncertain prognosis regarding the life of the mother or the foetus. Different approaches are solved at the European level through the Ethics Working Group of Confederation of European Specialists in Paediatrics (CESP). This working group evaluates ethical practices in different countries (Čepický 2011a). During this period, there are numerous ethical issues. Medical ethics is currently seen as a multidisciplinary field. Its influence is more often reflected in the everyday work of doctors and non-medical staff in the health care professions (Čepický 2011b). It is an integral part of educational programmes of universities.

Many common developmental defects arise through the joint impact of external or teratogenic effects and internal or genetic factors, (i.e. on the basis of multifactorial inheritance). In 50–60% of cases, the causes of congenital defects remain even

nowadays unclarified (Havlisová 2012). Down's syndrome is a frequently discussed congenital disease. There are parents who cope with this diagnosis in their child. They support this and rejoice. On the other hand, many parents give such an affected child after birth to an institution (Zlatohlávková 2011). Do the children with Down syndrome keep full life? This is the question, which every person answers in their own way. New diagnostic methods, sometimes collectively called "preimplantation genetic analysis", can reveal these developmental disorders, but at the same time it forces us to address a range of ethical questions (Roztočil et al. 2008). This analysis is now prohibited in Germany and Italy, but it is already permitted in USA, Great Britain, Israel, India and China (Havlisová 2012).

The constantly repeated philosophical question, when the life of a new born begins and which life is worth protecting, is still relevant today. Prenatal diagnosis, however, solves, as already mentioned, problems of morbidity and mortality of the population, but from a spiritual point of view it is all about the end of life (Prekopová and Šturma 2012). So, is it humane to terminate a pregnancy of an affected foetus? Why and under what circumstances is it possible to decide about this procedure? Deciding on prenatal diagnosis and its use should be carried out in cooperation with gynaecologists, specialists in genetics and paediatricians – neonatologists. The final verdict, however, must be decided by the parents. A fundamental ethical question at this time is, whether a woman can decide about the life or death of her unborn baby, and which psychic consequences she will encounter if she decides to end the pregnancy. If abortion happens, whether in an artificial or natural way, this condition is called "survival syndrome after abortion". The symptoms develop gradually, lasting at least one year, but sometimes they persist over one's entire life (Lehotská 2005).

One of the other ethical dilemmas is the question of so called "uterus rent". But these are not only technical, economic and legal problems, but they are mainly ethical problems. This pertinent designation is often avoided, but in my opinion, it describes in the best way the situation sometimes mistakenly referred to as "surrogate motherhood" or

"surrogate pregnancy". We cannot call this act motherhood, since this word is associated with higher values and other factors. Neither does the designation "surrogate pregnancy" have the correct meaning. It would be rather called "alternative pregnancy" (Vondráček et al. 2009). The pregnancy period is performed by another woman who is not the future mother. A woman, willing to insert the fertilized ovum, bears the embryo of biological parents. The "prayed child" may arise when the future father quite naturally fertilizes the surrogate mother or he gives his sperms which are then inject into her uterus.

If parents want unambiguously their own genetic offspring, the fertilization can be performed from parental gametes (an ovum and sperm of parents) in natural way (IVF), which involves inserting an embryo into the uterus of a surrogate mother. In another case, it is possible to use donor gametes in combination (father's sperms and a donor ovum or vice versa), or even both donor's gametes. This act definitely cannot continue without legislation. It is not possible to rely on the right judgement of health care facilities though they would operate in compliance with the latest medical trends (Attl 2009). After the birth, the woman, who is bearing the child disclaims all parental obligations and allows to ordering, mostly biological parents the adoption of a born child. In a birth certificate the name of a biological father is already stated, so the child is administratively adopted only by a future mother. In postpartum period it is very difficult for the surrogate mother to give up the delivered child. She often must seek psychological help to cope with this life situation. On the other hand, expectant parents can experience fear whether the handover of a child will realize. Currently, there is no law in the Czech Republic which would solve this situation, therefore we use only existing standards.

The delivery is a landmark life situation for the mother. A physiological delivery which takes place in the hospital has its positives, but also some negatives. A comprehensive care for a mother and a child is, of course, beneficial if complications should arise. On the other hand, the risk of separation between the mother and her infant and the hospital environment has a negative effect on mothers during labour. Prof. PhDr. Z. Matějček, Csc.,

a globally recognized child psychologist (Matějček 2006) was the first in the Czech Republic who fought against the separation of the mother and the child, and who started the rooming system.

Health professionals often neglect the fact that the greatest expert on motherhood and childbirth is the mother herself (Mrowetz et al. 2012). When questioning the quality of postnatal services, 83% of respondents evaluated very positively the continuous contact of the child and the mother in the period after the delivery (Camacho 2012). Unfortunately, Czech maternity hospitals still have resources. There is also an absurd distortion of roles which appears. The doctor and his prescriptive approach act as professional instead of the mother. A doula plays the role of midwife, and a labouring woman is subjugated person who must adapt to the entire situation. Maternal instincts are given to women by nature. They have a grater connection between brain hemispheres, they have more interconnected thinking and feelings. Therefore, the first experience with the mother plays a key role (Prekopová and Šturma 2012). In this emotionally tension period, it is necessary to approach the woman very carefully, and consider each word, each contact, each smile or complaint. Equally important is the role of baby's father. One of the stages of a relationship involving partners is the stage of a complete family. It begins in antenatal period and fully develops after the baby's coming. Emotional relationship is established by both parents, while in woman, as already mentioned, it is stronger. The new situation may even significantly threaten the partner links. We talk about so called "pregnant parents" (Velemínský 2011).

Natural childbirth is a process which takes a natural course. However, mothers are often overwhelmed with this situation. The pain is too strong and the childbirth does not progress. Therefore a decision is made to terminate the pregnancy in an operational way. A Caesarean section separates the child from the mother, but there are considerable risks and complications which increase both during the operation and in the postoperative period. Many women do not realize that after the Caesarean section they may even experience feelings of inferiority and inability to raise a child to the world in a natural way.

Although the support of bonding should be stronger due to immunological and hormonal processes, it does not often work (Mrowetz et al. 2012). Another negative aspect is longer recovery period and therefore a longer stay in hospital. A healthy newborn is released at 72 hours of its age, but in case of operational labour the baby must wait for the mother (Gregora and Velemínský 2010).

There are also insurmountable risks associated with other pregnancies, such as increased incidence of placenta previa or impending rupture of the uterus in the place of previous cut. Thanks to Caesarean sections, the woman may be protected from labour pains but she cannot avoid the surgical pain. It depends a great deal on the obstetrician, whether in operational or spontaneous labour, on his technique and friendliness. If the baby, immediately after the birth, is placed on the mother's abdomen, it is then desirable not to disturb for at least a few minutes (Mrowetz et al. 2012). This technique is called bonding or "parental arms". This is an early and continuous contact between the new born baby and the mother, and is referred to as bonding and attachment. Only the mother and her child are experiencing a special balance at the moment. The delivery can be seen as a detachment, but not as final. The relationship must be re-established and to continue a loving and empathetic dialogue and for the baby to find the safety with the mother. First, the baby develops in tight embrace in the mother's abdomen and then it is born. It passes through the birth canal and settles in her arms (Prekopová and Schweizerová 2008). The first contact should be undisturbed. Each bond, in which oxytocin is secreted, concerns only pairs. This method of treatment was pioneered in the 70. of the last century by paediatricians in the USA John Kennek and Marschal Klaus (Mrowetz et al. 2012). In our country at that time, doctors just began thinking about problems caused by separation of the mother and her child.

Since 1974 a unique labour approach is promoted by Frederick Leboyer. His ideas are timeless. Unfortunately, not enough attention is paid to them. The concept, nearly 40 years old, carries a lot of experience and wisdom. This outstanding obstetrician was the first to challenge the western style of childbirth and suggested these changes: subdued lighting,

soft sound, the separation of umbilical cord after a few minutes, mild massage of a newborn and its washing with warm water. His revolutionary method of childbirth and postnatal care still amazes. It is a simple and efficient postpartum birth approach. Leboyer called it the theory of five landings (Leboyer 2010). Our previously institutionalized health service only slowly reveals that such performed labour fits not only to mothers but also especially to newborn infants. A child born into a stressful environment has a face with a furrowed forehead, eyes shut tight, trembling eyebrows and mouth corners pulled down.

Leboyer described this facial expression as the “mask of anxiety”. The experience of a newborn during the birth is enhanced by the contrast of the environment before and after the birth. A newborn baby feels and perceives with all their senses. It is not born blind, but immediately after the birth it is blinded with a number of fluorescent lamps in the delivery room. Once the head emerges, we can often see that a baby opens its eyes but closes them again and then, crying of a newborn baby follows. Also, children are not born deaf but immediately after the birth they are deafen. The sounds of an outside world through the thick abdominal wall and the amniotic fluid are significantly inhibited until the birth. And suddenly nothing protects a newborn's hearing and the sounds surround the baby with full force. The skin is soft, weak and sensitive. The skin, accustomed only to fine touch of placenta before birth, is suddenly exposed to cold and rough diapers. At the end of the prenatal period, the whole body is curled up in the womb with the spine permanently bent. Then suddenly, the body is stretched by nurses while measuring the infant's length. According to Leboyer, a newborn baby needs touch, tenderness, and both a dark and calm setting (Leboyer 2010). If we imagine the environment the baby comes from, we cannot disagree. Why are children not born in a world without confusion, noise, pain and disturbing impacts?

In the postpartum period of a newborn care, we must not forget the opinions of child psychologist Jiřina Prekopová. In her work she, apart from other things, reflects on the needs of a child who is immediately separated from the mother after the birth. These are sick or premature newborns, especially in cases when the separation from the mother is unavoidable. Let us empathise with the needs of a newborn child. According to Jiřina Prekopová, the ideal incubator should look like this:

- It should provide the newborn restricted space, have a dip where to lay softly.
- It should move rhythmically and have set the frequency of the mother's breath.
- An essential part should be a record of mother's heart beat.
- A piece of mother's clothing with her scent should be placed in the incubator.
- The room with the incubator should be painted in fine red colour and have adequate lighting.

It is necessary to keep in minds these recommendations and to maintain a premature baby in its prenatal environment. At present, neonatal wards try to provide babies with reduced lighting, silence, minimum invasive care, positioning in a confined space and especially maximum contact with parents from the first day of life.

CONCLUSION

Mankind will never find clear answers to some of these questions. There is a need to consider new possibilities and new methods especially in health care and to discuss their benefits. Not everything new must necessarily be beneficial. Unfortunately, thus far no modern technology can give the parents what they want most – the assurance that their baby will be born healthy.

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Caring for a healthy newborn infant

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Abstract

This paper describes the method of the newborn skin to skin care. In this process, an immediate and direct skin to skin contact between mother and newborn is applied immediately after birth till first feeding. Its advantages and beneficial effect is so pronounced that it is recommended to use it in a later period as well. This paper reports a practical procedure to apply the method of skin to skin immediately after birth and also in later period.

Key words: skin to skin; bonding; kangaroo care; newborn

“Responsible parenting is not necessarily a gift bestowed by the Mother Nature or just an acquired talent. It happens very often that it has to be learned.”

Peter G. Fedor-Freybergh (2013)

Similar to dramatic changes in the child in the postpartum period, which enable the baby to continue to live at fundamentally different conditions; vital signs of the child during pregnancy have been long shrouded in mystery. Until the last decades of the last century, the child was considered to be passive and care guidelines dealt mainly with regular feeding routine and strict hygiene. Advanced research methods revealed significant insight into the development of mutual relationships between the mother-to-be and her baby at the level of biological and psychological processes. The notion of passiveness of the child before its birth was derived from the knowledge of its ability to “learn”, which is very important for its adaptation to fundamentally new conditions after birth. Even full-term newborn infants are born with immature functions, in particular of the brain, and the best conditions for maturing are ensured in close contact with the mother – skin-to-skin (Haľamová et al. 2012).

Delivery is an important event both for the child being born into the world, as well as for the mother who gives life. Course of the birth can be decisive for their further growth and development. Childbirth, in a broader context, is not only the delivery of the foetus, i.e. the newborn infant, but primarily the start

of something unique. It is the birth of the mother and of the new being – her child.

The first minutes and hours after birth are an important time for both parties involved in the childbirth (the mother and the baby). According to Dr. Odent (1995), the course of this time can partly determine what kind of relationship children would have with their mothers. Subsequently, this may have an impact on their approach to other people and the world around them. The immediate postpartum period may have a significantly influence on one's personal capacity for love and for developing emotional ties. Therefore special care should be taken to ensure emotionally warm and encouraging environment that facilitates the intimate contact between the mother and her child in these moments.

The hours and days after birth are a sensitive period of time when mothers are uniquely set up to care for newborns and infants have almost magical powers over their caring parents. The time that mothers and infants spend together after birth and later allows the influence of the natural behaviour of the baby to appear. This interaction facilitates establishment of a mutual bond and instinctive biological caring skills of the mother. The child has its needs and the

mother is ready to satisfy them. The child should spend all the time from the moment of birth in continuous skin-to-skin contact with the mother (Poloková 2011a).

According to a general definition, skin-to-skin is a process of providing a straightaway and direct skin-to-skin contact between the mother and the newborn immediately after birth until the first feeding. The World Health Organisation (the WHO) considers this method to be very effective in the body thermoregulation, breastfeeding support and emotional bonding, regardless of the place, weight, gestational age and condition and equipment of hospitals (WHO 2003).

General benefits (other than financial), which are described, include a “closer relationship between the mother and the child”. It gives the baby the reassurance it felt in the mother’s womb. The child hears its mother’s voice and the beat of her heart. This approach supports psychological status of the mother and improves her confidence. It supports lactation by elevation of oxytocin levels, making it easier to release milk from the breast (Jánoš 2003). The skin-to-skin method has a positive influence on physiological functions of the infant in the early post-natal adaptation. Infants treated using the skin-to-skin method have a more stable body temperature, lower incidence of irregular breathing and apnoea episodes as well as more regular heartbeat than newborns treated using the standard method of swaddling or placed in incubators separated from their mothers (Moore and Anderson 2007).

The skin-to-skin technique should not be restricted only for about the 60 minutes until the first feeding, but it should be extended for an unlimited period of time as needed by the mother and the baby (Sears and Sears 2012). This process of mutual “attachment” and “clinging” in the neonatal period is called bonding (Hašto 2005). Higher weekly weight gains, lower incidence of infectious diseases, abdominal pain and baby colic are reported during intensive application of this practice (Smičková and Janos 2011). Positive effects of the skin-to-skin method can be seen also in neurobehavioral signs in neonates. Newborns treated by this method are less tearful, spend more time in undisturbed sleep and their moods are calmer and more harmonious (Ferber and Makhoul 2004).

This close and intimate contact is mentally and physically crucial also for mothers. Mothers who were allowed a skin-to-skin contact with their babies were more likely to breastfeed for a longer period of time than the mothers who were partially separated from their babies. It is reported that mothers are more confident, better adapted to the maternal role, more aware of their responsibilities of child care and understanding of hospital care for the newborn; while more empathetic to perceive the child (Smičková and Janos 2011). According to recent surveys, the laying of the newborn on the mother’s abdomen immediately after delivery and the first latch to the breast is considered to be the gold standard to promote good development of lactation, effective separation of the placenta, uterus shrinking and evolution of the primary bond between the mother and her child (Poloková 2011b).

M. Mrowetz (2012), one of the most famous advocates of bonding in the Czech Republic and in Slovakia, describes how to facilitate bonding. She summarised up 10 steps to encourage early contact. Each step is explained in detail.

1. Put the naked newborn infant on the nude belly of the mother immediately after delivery – vertically.
 - If caesarean section was done, put the naked newborn infant on the mother’s chest under the breasts horizontally, ensuring that the surgical field is restricted under the breasts of the mother. The newborn infant is supported by another person if needed, so that the baby can effectively search for the nipple and latch to the breast. Electrodes should be placed on the woman’s back or outside her chest. Her arms should be released, if they have been strapped to the bed or a device, so that she can hold the baby to herself.
 - Dry the newborn infant on the mother’s body; wrap the baby and the mother as a single entity into warm towels and blankets.
 - The umbilical cord should be cut only when it no longer pulsates in order to ensure adequate placental transfusion.
2. Perform all examinations and basic treatment of the newborn infant on the mother’s body.

- Determine the Apgar score.
 - Clamp and cut the umbilical cord.
 - Label the newborn infant.
3. Facilitate and encourage visual contact – so that her eyes meet with the baby's eyes.
 - If the mother is lying on her back, put something under her head. Suggest her to wear a shirt with buttons to ensure a good view.
 - If the newborn infant must be placed into an incubator, they should be in one room. Visual contact can be only partially replaced by pictures, video or optimally by a web camera transmission.
 4. Breast crawl.
 - The infant and the mother should be given sufficient time in skin-to-skin contact to familiarise themselves with each other.
 - Allow 30 to 60 minutes for the newborn and the mother to prepare for the breast crawl. This time is much longer after medicated births and caesarean sections, and it can take up to several hours.
 - Let the infant crawl to the breast on its own, to find the nipple using all the senses: sight, touch, hearing, smell and taste.
 - Do not wipe its hands of amniotic fluid.
 - Look for the signs of the baby's readiness to suck: the baby is putting its hand into the mouth, salivates, opens the mouth, feels the areola and the nipple by its hand making the nipple ready for breastfeeding, with eyes wide open.
 - A contactless form of assistance is desired. You can help the mother to find a more comfortable position, to show her how to support her breast, offer some verbal advice. Only the mother should help the infant to latch; staff should wait and see.
 5. The mother and her newborn infant are in a skin-to-skin contact.
 - Encourage the skin-to-skin contact and do not interrupt it for at least 2 hours after delivery, ideally for 12 hours or continuously. The mother and the newborn are transferred from the delivery room to the postnatal ward together in skin-to-skin contact.
 - In case of caesarean sections, the father can substitute the mother. The father's bacteria are natural and beneficial for the baby.
 6. Health professionals should ensure a pleasant, quiet and intimate environment and comfort for the mother.
 - Separate delivery room where the whole family can be together.
 - Comfortable bed, armchair, pillows, warm blanket.
 - As few staff members as possible should enter the room so that the new family is not disturbed when they familiarise with each other.
 7. Technology should be eliminated – no cameras, camcorders, mobile phones.
 - No picture or video can substitute this unique moment.
 - A picture of the new family can be possibly taken by a staff member.
 8. Every examination and collection of biological material, follow-up checks and similar procedures should be done in the presence of the mother.
 - Examinations should be done and samples should be taken in the arms of the mother in skin-to-skin contact (to eliminate release of cortisol).
 9. Transfer to another facility.
 - Should it be necessary to transport the newborn to another facility, the mother and the baby should be transported together, depending on their condition, ideally in a physical contact.
 10. In case of stillbirth or death of the infant after delivery, encourage the mother to make a contact with her baby.
 - Allow the mother and the family to say goodbye to the baby – encourage skin-to-skin contact, arrange for a memory of the child (an imprint of the foot or hand), encourage the parents to see the baby.
 - The mother and the family should be given unlimited time to mourn. Inform them about the possibility of baptism after death and encourage them to organise a pious farewell to the child (Mrowetz 2012).

The kangaroo care method is used in further care for the infant in skin-to-skin contact. Used mainly in premature infants, it is recommended also for healthy newborns at

hospital and home settings. WHO defines the correct position in kangaroo care as follows:

- In kangaroo care, the newborn infant is held in an upright position between the mother's breasts, chest to chest with the mother. The baby's head is extended and turned to one side.
- The top of the cloth fabric (binder) is just by the baby's ear.
- This slightly extended position keeps the airway open and allows eye-to-eye contact between the mother and the baby.
- Care should be taken to avoid forward flexion and hyperextension of the baby's body.
- The legs should be flexed at hips and extended in a "frog" position; the arms should be flexed.
- The material of the cloth that surrounds the baby must be tied quite firmly so that

when the mother stands up the baby does not slide out. At the same time, the cloth should be tight over the baby's chest. Baby's abdomen should not be very constricted and should be skin-to-skin somewhere at the level of the mother's epigastrium. This way the baby is secured in a position that does not restrict its abdominal breathing. The mother's breathing stimulates the baby's breathing (WHO 2003).

To conclude, it can be said that the skin-to-skin method in newborn care is not particularly new or unexplored. Although most research has dealt with premature newborns and their better adaptation, there is no reason to doubt its beneficial effect on physical and mental development of healthy newborns. Its simplicity and affordability is one of the major advantages for practical use.

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Spiritual aspects of prenatal child

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Abstract

The interaction between mother and child during pregnancy has not only biological but also psychological, spiritual, and social aspects. The prenatal phase of human life is the most important and the most decisive for a person's entire life in psychological and physiological terms. It is the time period which bears the highest risk for the child's development as it is affected by prenatal stress experienced by the mother during pregnancy. Attachments between the mother and child, later affecting the entire life of an individual, are formed already during the prenatal period. This contribution describes possibilities for healing traumatic experiences that the child brings from the prenatal period. This healing aspect of the prenatal period proceeds through the attachment that a human being has formed with God based on his/her experience with attachment to the primary carer. Trauma caused by the mother, father, or other people during the prenatal phase of fetal development is healed through prayer, when the child returns to the respective time to live through the moments of trauma again, this time filled with love, joy, and self-adoption through Jesus Christ. This goal is studied based on authentic testimonies of witnesses who experienced healing, through prayer, of their own traumas suffered during prenatal fetal development.

Key words: *prenatal child; spiritual experience; trauma; prayer; healing*

Recently, we have experienced a transformation of the paradigm of knowledge about prenatal life. Science is gradually beginning to accept psychological aspects of pregnancy and childbirth. Hüther and Weser (2010) confirm that the results of research in neurobiology, psychology, and behavioral biology aimed at examining stress all together form a picture of an unborn child who develops mentally already in the mother's womb. Prenatal development teaches us that body and soul are inseparably linked. Whether a fertilized egg, embryo, or unborn child, it is always a living being, which combines the physical and mental components into a single unit. The human being does not arise with the body being first formed by the cells and the soul added thereto at some later time. During prenatal development, the soul of an unborn child develops simultaneously and inseparably to the same extent as the increasingly organized body.

Being formed during pregnancy, the attachment between the mother and child manifests itself by different ways and is subject to constant changes. Fedor-Freybergh, the

founder and pioneer of prenatal medicine and psychology, says (2013, p. 24) that "*pregnancy is a continuous adaptation process, both for the prenatal child and for the mother, which means that pregnancy is not a static process but a very dynamic developmental process with reciprocal relationships between the mother and child*".

Fedor-Freybergh (2013) clearly declares that the mother's attitude toward pregnancy is based on the basic structure of her personality, her previous emotional experience, past and current conflicts, insecurity, frustration, ambivalence, her own childhood and adolescence, her attitudes toward existence as a woman, motherhood, sexual experience, her relationship to her partner, mental and physical maturity, her socio-economic situation, and so on. We would like to add additional equally important factors, the spiritual memory of negative relationships with her mother or father, refusal of the life conceived in the womb of her own mother, complicated childbirth, or mother's postpartum depression.

The mental and physical burden experienced by the mother during pregnancy has multiple effects on the maturation and structuring processes occurring in the brain in an unborn child. If the nerve impulse schemes and irritating conditions occurring during pregnancy were regularly associated with changes caused by certain disorders of the neural connections, the neural networks and complex connecting structures in the brain of an unborn child will adapt to this situation. As a result, this may change the level of barriers that determine the extent to which the brain can conduct impulses arising from new stimuli. Or in other words, how difficult or easy the emotional centers of the limbic system in the child's brain will be activated in the next life based on previous experience. If the brain is forced to adapt its internal organization to prenatal influences by preventing the spread of these impulses, the ability of emotional responses will deteriorate. If the opposite is true, prenatal influences will force the brain to engage in greater stimulation of the emotional peripheries, and build the switches that direct further development in the opposite direction (Cassidy and Shaver 1999, Hüther and Weser 2010, Koukolík 2011, Fedor-Freybergh 2013, Hardy 2013).

The attachment theory talks about creating ties between the child and the primary carer of the newborn. This attachment will last for the entire lifetime and is used by an individual to create a mental representation of relationships with other people. Everyone is looking for his/her relational person, particularly those who have experienced traumatic childhood and their parents failed as primary carers. Experience with positive (calming, consolation, protection) and/or negative reactions of the mother (neglect, refusal, unavailability) is internalized by a child, who creates his own ideas and expectations about the support of the primary carer which is integrated into the attachment system (Hašto 2005, Bowlby 2010, Brisch 2011a, b). Safe attachment is one of the greatest gifts a human being can receive (Koukolík 2011).

We agree with the statement of Fedor-Freybergh (2008) that the attachment between mother and child begins to form already in the prenatal period, even when the mother begins to think about her future child. The attachment with the mother before

birth in particular has an influence on the development of the child in the prenatal period. We believe communication with the child is the most important channel through which the mother conveys to the child the feeling of being wanted and loved.

Prenatal stress experienced by a child during pregnancy is associated with the experience of memory traces that the child's mother experienced during her own intrauterine development. These experiences and emotions of the prenatal period are deeply rooted in the spiritual experience of the mother, which cannot be measured or seen. These feelings are experienced by particular individuals at a time when they are disturbed from normal experience. In expectant mothers, hidden events that the mother does not remember consciously begin to appear during pregnancy. The roots of many addictions in human beings lie in prenatal development, when the mother or father of the fetus did not want or did not accept the child. Mothers who have accepted a child and loved him/her since being in the womb, have healthier children, both emotionally and physically, than mothers who rejected their children. In research studies, several authors agree that a problematic marriage or relationship is one of the biggest causes of emotional and physical harm to the child in the womb.

We can agree with the idea that the mother's womb is the first world of the child. How it is experienced will affect the formation of personality and character traits. The period experienced in the womb predetermines the child's expectations about the world. If it is a warm, loving environment, the child is likely to expect that the world is the same. This creates initial conditions for the establishment of trust, openness, friendliness and self-confidence. If the environment of the womb is hostile, the child will expect that the world is unkind. The child will tend towards suspicion and mistrust.

The spiritual life of a human involves the formation of relational ties to God similar to the formation of attachment between the child and mother. It is very important to accept and understand that the attachment ties and all the patterns and manifestations can be transferred into a relationship with God. Based on several research studies,

it was found that one can accept God as a substitute of a relational person (Granqvist 2002, Kirkpatrick 2005, Moriarty et al. 2006, Rasar et al. 2013). Individuals with a safe type of attachment should see God as loving and caring. In contrast, avoidant individuals should see God as distant and inaccessible or cold and rejecting or simply non-existent.

Francis and Judith MacNutt (2002) recommend prayer, sometimes a prayer fight, to heal negative experiences of the prenatal period or even freedom when pain and emotional experience of the prenatal period were too traumatic. The feelings that an expectant mother or individual may experience include feeling of being unwanted, rejection, non-acceptance, worthlessness to feel being loved, feeling redundant, worthless, hatred towards the father, fear of childbirth, reluctance to live, suicidal attempts, existential fear, stress of abortion, self-hatred, etc. Lake (1981, p. 33, MacNutt and MacNutt 2002) wrote literally: "Woes to the fetus, whose destiny is to spend forty weeks on this deserted place as the womb of a mother who hates herself."

Testimony about healing of a man dependent on alcohol for many years from injury, which was a part of inadvertent conception: Jesus Christ enters each traumatic memory and pain of prenatal period to accompany us from the miraculous moment of cell-cell fusion until the birth. Jesus can heal any fear from the prenatal period and liberate the individual (Padovani 1999, Vella 2010). In each story of healing, he clearly lets everybody re-live the experience that he/she has been a beloved child since the conception, because God wanted to have him/her here. Preterm birth or prolonged separation from the mother after birth is crucial to the emotional life and psychological problems of the individual.

Testimony about healing of a man dependent on alcohol for many years from injury, which was a part of inadvertent conception:

"Do you remember the time when you were in the womb?" asked me the Lord. A few months prior to this event, I clearly recognized in my prayer that my parents did not want me. When he asked me this question, I found myself again in my mother's womb.

Jesus was with me and helped me remember it. My mother became pregnant with me nine months after the birth of my older brother. Then Jesus led me through these events: my mother was afraid to tell my father that she is in the blessed state, knowing that he will be furious. When she could no longer hide her pregnancy, she told him about it, and he slapped her in the face in a rage of fury. My parents had many terrible quarrels because of my conception. Neither of them wanted me to be born. At the end of the pregnancy, my father hit my mother in the belly wishing that I would die before I was born. After these things Jesus said: "I wanted you to be born. I wanted you in my world." Now, for the first time in my life I am free from internal bifurcation, which restricted my every relationship and success in life. I've never been sure that I want to live, nor about whether I want to be successful at something. And this despite the fact that I was considered a very capable, productive man by others.

Here is another testimony about the healing of a woman who was born prematurely and suffered from feelings that she is unwanted and unloved:

During the prayer for inner healing, I was healed beautifully and I saw myself in the hospital obstetric room where Jesus was with my mother and doctor. Jesus gently encouraged me that I was born. I distinctly heard him saying: "Nan, it's okay – I'll be with you, you don't need to be afraid to be born." (I was afraid to be born, because I had been born three months earlier and weighed just about three pounds.) Jesus kept making me sure that I would be fine. Then I felt that I was born. Jesus was there and held me, comforted me and loved me. Later, while I was in an incubator for six weeks, I saw how Jesus caressed me and loved me. I remember quite clearly that as a toddler I felt that my parents did not love me. When I said it to my mother as an adult, she began to cry and said that neither she nor my father could take me in their hands, until I was six weeks old. They did not allow them to. For the first time after 24 years in this world, I felt love and interest about myself. I also found that I stopped being afraid of crowds.

Here is the testimony of a woman, who was hesitant about conception, regarding

the consequences of her indecision and subsequent healing of the injured relationship with God, her husband and child:

During the Vietnam War, my husband was on the list of those who were to be called. He was very afraid that he might die so he asked me to become pregnant so that he could get a deferral due to fatherhood. My heart was gripped by anxiety, because I loved him and wanted him to be happy, but I also wanted my dreams come true and become a nurse. I got pregnant, but I was hesitant and did not like the child in my womb. When my son was finally born, we found that he was affected. He was a mildly retarded and demanding child. At the military medical examination, my husband received a deferral due to health reasons. I felt great anger and resentment. I was angry at God that I had received such a burden for no reason! I was filled with self-pity. This was the beginning of many years of struggle and unrest in our marriage. Once we invited friends, whom we trusted, for dinner to help us. After meeting our son, our friends exclaimed: "What a blessing this baby is!" I was shocked and thought to myself, "How could such a small child ruin my whole life!" Although I still hurt my son in many ways, he loved me more and more and accepted me as I was. Then I attended lectures on healing and during the prayer I experienced an amazing recovery. I saw how Jesus took a seed from my heart and held it in front of me in his hands. His face was amazingly full of love. The seed shone filled with light. I took it and saw I was pregnant. Then Jesus walked with me and the angels sang to my son and told him how much he is loved. I asked Jesus to give him everything I had not been able to give him. Then I saw myself in a hospital and Jesus was the obstetrician for my own son. He handed him to me and I held him to my breast with great love.

Only God truly knows our inner self, thinking, survival, our past and future. The prenatal experience is described in the following psalm: *"For you formed my inward parts; you knitted me together in my mother's womb. I praise you, for I am fearfully and wonderfully made. Wonderful are your works; my soul knows it very well. My frame was not hidden from you, when I was being made in secret, intricately woven*

in the depths of the earth. Your eyes saw my unformed substance; in your book were written, every one of them, the days that were formed for me, when as yet there was none of them" (Ps. 139, 13–16, The Bible, 1996, p. 1167).

When a child is born, the most important phase of its development has already been completed. It is extremely important that everyone pray for inner healing of his/her own conception. Everyone is affected at the emotional, physical, and mental levels by the prenatal experience he/she passed through. While we cannot change the effects of prenatal development, we can pray for healing of the days and situations that have negative effects on us during our adult lives.

For believers and those who desire healing, prayer is important for healing their own prenatal period so that everyone can feel free of all traumatic effects originating from conception and the relationships with our parents:

"Heavenly Father, the Creator of all that lives, my Creator, come back to my very inception. Fill the moment of my conception with all the love and joy that you always wanted me to have. I know you planned my life with eternal love, dating back to the very beginning of the world. Please let me know in my heart of hearts. Let me know how much you longed for me. Fill places of darkness in my heart with life and with love. Liberate me from every feeling of self-reluctance and worthlessness. Let me know without a single doubt that I am Your child. Fill me with all motherly and fatherly love that I needed so much (a) and missed. Make the very second that I began filled with Your light and love."

Parents' prayers for their child who is waiting to arrive into the world are an important part of the child's prenatal development. If a significant number of parents will pray for their conceived children, there will be a quiet revolution. Children to be born will become a new, different generation, more inclined to spread good as well as happier and more full of joy.

Let's conclude this article with the words of Fedor-Freybergh (2013) that we understand, with God's help, that human life is full-featured from the very beginning.

The life, existence, and integrity of the child is most influenced in the prenatal phase of life. Happy is the child who is beloved in the prenatal period.

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