

Interpreting the Dread of Being Aborted in Therapy

John C. Sonne

Moorestown, NJ, USA

Keywords: Prenatal trauma; Dread; Abortion; Survivors; Transference

Abstract: This paper will illustrate how the sequelae of prenatal trauma can be differentially expressed in a variety of pathological symptoms in postnatal life. An in-depth examination, based on a receptive posture in the therapist, often reveals that the traumatized unborn in the patient has developed a congenital diathesis which has predisposed him to have repeated postnatal reenactments symbolic of the original pre-natal trauma. This diathesis cannot automatically be assumed to be an expression of genetic endowment. The ambient psychological family is an important determinant in both the causation of prenatal trauma, and its healing or reinforcement in postnatal life. The meaning of the messages communicated by the traumatized unborn are “known but unthought” by the patient until the associative links are interpreted in therapy. Such interpretations require the therapist to think in terms of prenatal mentation and communication, and to consider the dread of being aborted as a possible component in the transference, and also in common syndromes that have been traditionally viewed and interpreted as primarily having a postnatal origin. Failure to do this may result in an interminable or unsatisfactory therapy. Ten clinical case examples will be presented.

Zusammenfassung: *Die Interpretation der Gefahr, in der Therapie abgetrieben zu werden.* Dieser Artikel will zeigen, wie sich Auswirkungen von vorgeburtlichen Traumata in Form von Übertragungen in unterschiedlichen pathologischen Symptomen im nachgeburtlichen Leben ausdrücken können. Eine in die Tiefe gehende Untersuchung, wobei eine ganz offene und unvoreingenommene Einstellung des Therapeuten Voraussetzung ist, enthüllt oft, daß das traumatisierte vorgeburtliche Kind im Patienten von Anfang an eine Veranlagung entwickelt, aus der heraus es zu wiederholten nachgeburtlichen symbolischen Reinszenierungen des ursprünglichen pränatalen Traumas kommt. Diese Veranlagung kann nicht einfach als Ausdruck einer genetischen Anlage betrachtet werden. Die umgebende Familiensituation hat entscheidenden Einfluß sowohl bei der Verursachung des pränatalen Traumas wie auch seiner Heilung oder Verstärkung im nachgeburtlichen Leben. Die Bedeutung der vom traumatisierten vorgeburtlichen Kind im Patienten ausgehenden Botschaften sind

Correspondence to: John C. Sonne, M.D., 443 Shady Lane, Moorestown, NJ 08057, USA, Telephone and Telefax (609) 2353558

Paper presented May 12, 1995 at the XI International Conference of the International Society of Prenatal and Perinatal Psychology and Medicine, “A Time to be Born”, Heidelberg, Germany, May 11–14, 1995.

für diesen „bekannt, aber ungedacht“, es sei denn, die assoziativen Verbindungen können in der Therapie hergestellt und interpretiert werden. Solche Interpretationen verlangen vom Therapeuten, daß er sich in das vorgeburtliche Erleben und die vorgeburtliche Beziehung einfühlen kann und ebenso die Gefahr, abgetrieben zu werden, als eine mögliche Komponente in der Übertragung und ebenso in allgemeinen Syndromen, die herkömmlicherweise als postnatal verursacht angesehen werden, annehmen kann. Wenn solche Verbindungen nicht hergestellt werden, kann dies zu einer unbeendbaren oder unbefriedigenden Therapie führen. Hierzu werden 10 klinische Fallbeispiele darstellt.

Introduction

An increasing body of evidence has been accumulated in recent years documenting the fact that there is a great deal more mentation and communication occurring in the unborn than had been previously thought (Cheek and LeCron 1968; Liley 1972; Verny and Kelly 1981; Grof 1988; Wilhelm 1988; Janus 1989; Piontelli 1992; Chamberlain 1994; Sonne 1994a, 1994b). This knowledge is fostering an increased interest in the study of prenatal trauma, when and how it could occur, and how such trauma, particularly if it involves the threat and dread of being aborted, might find expression epigenetically in self-object and psychosexual processes in post-natal everyday life. One of the early psychoanalytic writers interested in this area of research was Ployé (1973), who suggested in his little noted but seminal article, “Does Prenatal Mental Life Exist?” that psychoanalysts might well pay more attention to the possibility that threats to life experienced by the fetus prenatally could not only be imprinted, but that they could find expression symbolically in dreams and everyday life experiences. Ployé even went so far as to wonder about the symbolgenicity of molecules.

In two previous papers, “The Relevance of the Dread of Being Aborted to Models of Therapy and Models of the Mind: Part I, Case Examples, and Part II, Communication and Mentation in the Unborn,” I (Sonne 1994a, 1994b) have outlined the characteristic patterns of thinking, feeling and behavior of abortion survivors, presented evidence from a variety of disciplines documenting that there is much more communication and mentation in the unborn than has generally been held to be true by the majority of scholars and clinicians in the psychological and social sciences, presented evidence documenting the occurrence, registration, and post natal sequelae of psychological trauma to the unborn in the prenatal period of development, and proposed a hypothesis to explain the mechanism for how prenatal trauma is imprinted. In this paper I shall suggest ways in which one can make a diagnosis that someone is likely to be an abortion survivor, suggest ways in which the abortion dynamics evident in the patient’s associations and in his transference may be elicited and interpreted, suggest ways in which a new way of thinking, feeling and behavior may be facilitated, and give some examples of the dramatic changes occurring in people when they consciously recognize their previously repressed and denied dread of being aborted, and understand and no longer need the variety of mental and social mechanisms of defense they have used to handle this dread.

The masculine gender has been used in this paper at times for convenience, with the understanding that it is to apply to both sexes.

The Therapist's Mental Set and Posture

The most important characteristic necessary in the therapist, if he is to be successful in hearing, eliciting and interpreting the dread of being aborted in therapy, is for him to, at a minimum, not have a closed mind to the possibility that there is more mentation and communication in the unborn than he has perhaps generally thought, and to be open to hearing statements from his patient that at first thought might seem to him to be incredible. Do not categorically fix in one's mind that psychology begins at birth. A closed mind on the part of the therapist will likely lead to failure or an interminable therapy, a common story heard from abortion survivors who have sought prior help. Even if the therapist is skeptical, it is important for him to at least consider that what the patient is saying might possibly be true, and to not be suppressive. Most scholars and clinicians who have become interested in this area, and have studied it, were originally skeptical. Only over time did they become more convinced, as they listened, observed, saw changes in their patients, and learned from the research findings of other scholars. Once the therapist has become more open and at least partially convinced, he will begin to see more and more, and his work will become easier. He will feel a tremendous sense of liberation, a clarification of his own thinking about human life, and he will be rewarded by vicariously enjoying the resultant gratitude and happiness of his patient.

Characteristics of Abortion Survivors

Although abortion survivors may have a variety of obvious symptoms, it is important to also note the presence of a variety of more subtle but pervasive unusual characteristics in their thinking, feeling and behavior. Both the obvious symptoms, and the subtle characteristics, are clues which can help in making the diagnosis. They will ultimately be seen as transferential derivatives from prenatal trauma, even though the abortion survivor initially has little awareness of their repressed traumatic origin.

Abortion survivors have a sense that they are not present, do not feel real, and that life has little meaning for them. Although time passes, they have a sense that nothing is happening over time, and with this have an accompanying sense of timelessness and equilibrium. They often describe themselves as drifting through life, and frequently regard themselves as incurable, often on the basis that they consider themselves genetically flawed. Their efforts to convince the analyst of their inherent defectiveness can often be so unrelenting that the analyst may be tempted to accept the abortion survivors' hopeless conclusions about the unalterable genetic determination of the difficulties they have had with life since the day they were born. The fact that certain individual and interactive characteristics may have been manifest congenitally, however, is not proof that they are genetically determined. The therapist needs to remind himself of the demonstrations by Kandel (1989) and Edelman (1989, 1992) that genetic programming is not immutable. They have demonstrated that neuronal networks, also called neuronal maps or neuronal varicosities, are plastic. Depending on one's experience, previously dormant genes can be activated and previously active genes can be deactivated through a process of degeneration and re-entry. Their work supports the

possibility that experiences in utero may have already altered genetic expression before one is born.

Abortion survivors make limited use of poetic metaphors and metonyms in their speech, and have little sense of humor. They are half-alive and half-dead. They have extreme difficulty trusting. They are not thankful, grateful or appreciative. They do not feel present or connected, and do not believe in the soul or in God. Their abortion wishes and fears are acted out in social relationships, and can come to the fore in therapy in the transference. They not only fear being aborted, or in effect aborted by being interminably confined, they also wish to have been or to be aborted or otherwise disposed of. They want what they fear, and they are what they hate. Seeing themselves as loathsome, dirty, defective, incurable, unworthy, and discardable, abortion survivors tend in part to regard the traumatic abortion threat experienced by them prenatally, and the poor treatment they often experienced postnatally, as justified. They have identified with the aggressor, the abortion-minded mother and/or father, or the indifferent world, and when in a suicidal mode they almost seem to seek, and often experience, repeated psychological abortions from their intimates or from their therapist. If the dynamics are intense, there may be gross acting out in the form of actual suicides. Not only are they suicidal, they are also homicidal. In a homicidal mode they will attempt to abort, or sanction the psychological abortion of, any potential competitor or potential friend, including their therapist. Similar to abused children who later become abusers, they are also inclined to act out by aborting others, including their own children, or to sanction the abortion of others, either psychologically or physically. They feel resentful and hostile toward anyone whom they feel competitively threatens or has threatened their existence, including siblings and the sibling substitutes they see in the world around them. Although many fearfully cling to or remain trapped and frozen in situations offering a dubious security, some act out their fears and wishes dramatically in relation to tunnels, caves, bridges, airplanes, and in daredevil, sensation-seeking, counterphobic, death defying, risk-taking activities such as spelunking, hang gliding, parachute jumping, motorcycle or automobile racing, flying, white-water rafting and scuba diving. Some tend to be episodic wanderers.

The hostility and fear present in abortion survivors do not seem to be primarily connected with a desire for gratification, resentment at not receiving it, or resentment toward a competitor who interferes with their gratification, as would be the case when one feels frustration during various vicissitudes of psychosexual development until these feelings are resolved in a healthy Oedipal resolution. Nor do the hostility and fear seem to be very much about the need for affirmation of self or affirmation of one's gender or identity that is operative in the various stages of separation and individuation beginning in early childhood that have been delineated by such researchers as Winnicott (1949), Erikson (1950), Jacobson (1964), Blos (1967, Mahler (1975), Kohut (1977), Bowen (1978), and Stern (1985). The hostility and fear seem to be connected with a very early prenatally originating basic and most primitive fear that one will be destroyed before one even has a chance to struggle with the self and desire vicissitudes of early infancy and beyond. One hasn't a chance to have one's feet on the ground to even start living. One is not connected, and cannot aspire to higher levels of fulfillment and gratifica-

tion. The most one can hope for is momentary, fleeting, sensual stimulation, that gives some partial sense that one is alive. This is often experienced in impersonal sex, drugs, and masochistic and sadistic acting out. Nothing has been sacred for abortion survivors, so nothing is sacred to them.

The Prenatal History

Either in taking an initial history, or here and there during the course of therapy, obtain as much information as possible about the patient's prenatal history, either from the patient himself or from his family. This may take some inquiring from the therapist, for the conventional method of history taking generally has not focused on this, and patients themselves often do not volunteer much. They may or may not have been told much by their family. What they were not told and what they were told are equally important. The patient can also seek more information about his prenatal life if his parents or other relatives or friends are still alive, and from records if they are available. What were the family circumstances at the time of his conception and during his time in utero? Was the pregnancy planned or unexpected? What was the family's reaction upon hearing of the pregnancy? Was he wanted? If so, did both parents want the pregnancy or just one? Does the patient know whether the parents especially wanted a boy or a girl? Was there much talk in general in the family of mothers who became sick during pregnancy or died in childbirth? Were there any abortions in the family? Any miscarriages? Did anyone in the family suggest that he be aborted, or was there an actual attempt or attempts to abort him. Was he given up for adoption, or raised by a family member or members other than his two parents? Were there physical or psychological problems, or serious family conflicts during the pregnancy or during the delivery about which the patient was told? What was his birth like? Were there episodes of physical violence between the parents, or loud verbal battles with a great deal of screaming and yelling? What was the family's attitude about abortion? One often finds a dysfunctional family tree with several past abortions on its branches, often on the part of extended family members, and often covering several generations.

The Initial Opening

Although the therapist may have gained several clues from his observations and history, there must be an opening from the patient to proceed further. Often this can come spontaneously, accompanied by a dismissal that the comment could be significant. One patient brought the subject into the therapeutic theater by jokingly saying that, as a twin, she had had to elbow her brother out of the way to have enough room. Much was to follow. Another said, after my inquiry into what she thought her prenatal life might have been like, "I don't know, but I know that after nine months I couldn't wait to get the hell out of there." One patient speculated that she couldn't have felt very secure, knowing that her mother did not want to have another child, that her father had forced himself on her mother, and that her mother had turned her postnatal care over to the father and relatives immediately after her birth. If the patient had already been told that he was unwanted,

or that attempts had been made to abort him, the subject is easily opened up for examination.

Case Examples

"Oh No!"

This patient, who had said that she had wanted to live only once or twice in her entire life, was told repeatedly that her family's reaction upon hearing of her conception was to gasp, "Oh, no!" Her mother had had repeated abortions prior to the patient's birth, and some of the aborted fetuses were kept in jars on the mantle over the fireplace. Throughout life the patient was

preoccupied with a fascination for nests and cozy places. She became pregnant by her fiance while in therapy with a previous therapist. Without asking her how she felt, the therapist told her, "Of course you'll make immediate arrangements for an abortion." The abortion was a horrible experience for the patient, who said that getting pregnant was a punishment and that the abortion was another punishment. Every year thereafter she and her now husband experienced an anniversary "death day," grieving over their lost baby. During her experience with me she had a dream that she was nursing at her mother's breast and her mother seemed annoyed, and acted as if she wanted to get rid of her. She told this dream to her mother, who responded, "I don't know why you always feel so guilty. You didn't do anything."

"The Magic Baby"

The birth of this patient, a twin, was a surprise to everyone. No one knew she existed prior to her birth, and no one expected her to emerge after the delivery of her brother. The story of her birth told to her by her family was that seeing her appear was like seeing a timid animal being pulled out of a hat by a magician, and she was given the nickname, "Bunny." Her mother had a post-partum depression following her birth, and her father directly told her during her childhood that she was responsible for her mother's mental illness. In her family she was constantly overshadowed by her outgoing, obviously favored twin brother, felt guilty about any aspirations of her own, and was generally regarded as the problem sibling. She felt responsible for indirectly having made it "necessary" for her father to have several extra-marital affairs, and accepted an assignment from him to take care of her mother whenever she had a recurrence of her illness. During one of these frequent recurrences, when the patient was an adult, her mother committed suicide in her presence. At her father's insistence she married a man she had doubts about, by whom she quickly had two daughters and a son. Her husband was repeatedly unfaithful, was in and out of mental hospitals, was alternately charming and abusive to anyone close to him, and she eventually divorced him. He committed suicide many years later, leaving a note saying that no one cared for him.

She came to me having been previously diagnosed as suffering from a manic depressive illness, but I changed the diagnosis to masochistic character, and gradually weaned her from medication. She was plagued with guilt over an abortion one of her unmarried daughters had had, and guilt over the suicide of a second

daughter who had a baby out of wedlock a few years later, gave the baby up for adoption, and then committed suicide. She felt guilty about having divorced her mentally ill first husband, and for not having solved the problems of her extended family, which included numerous suicides other than the ones already mentioned. She drank and ate excessively, accepted abuse from her second husband as a “mental case” he had to take care of, and had repeated infections and skin lesions which dripped with blood.

Her initial foray into discussing her prenatal experience came out by her light-heartedly joking that there wasn't enough room for both herself and her twin brother in the womb, and that she had to keep elbowing him out of the way to have enough space. During her therapy I would gently, but repeatedly, almost offhandedly, draw her back to her prenatal experience, interpreting to her the prenatal masochism about which Kestenberg and Borowitz (1990) have written. It became somewhat of a standing joke between us that she knew I had this “thing” about prenatal experiences. Early on when she was feeling particularly guilty and ashamed of her existence, I suggested to her that she might wonder what God would have to say about her life, rather than playing God herself. I pointed out that excessive guilt accomplished nothing and was destructive to herself and others. She said that I was the first therapist of the many she had worked with who brought God into her therapy. She reminded me years later of how helpful this had been to her, and how helpful it was to her and her family when she and they had to deal with her first husband's suicide. When she said after several years of therapy that guilt had prevented her from mourning and from being happy, I said, “You felt guilty before you were born.” Although incredibly talented and brilliant, she nevertheless had such a grandiose need to shine and be perfect, combined with alternating feelings of worthlessness, that it wasn't until she accepted being ordinary that she could truly excel.

“You Were Only a Period”

I asked the mother of this patient, who suffered from a life long dread of tunnels, fear of sexual intercourse, an inability to develop a close relationship with anyone, and a current fear of moving to a new house, whether her son had been a wanted child. She responded that she hadn't wanted to have a baby when she had become pregnant with him. She had asked her doctor to give her something to “bring on her period,” but he had bluntly responded, “What's the matter? You're not married? You have the baby!” When her son said to her that this obviously meant that she had wanted to have an abortion and had wanted get rid of him, and that he had heard of this before, his mother blithely responded that he wasn't him then, he was “only a period.” Despite this disclaimer, she sobbed without restraint, the only time she ever cried during two years of family therapy, and through her tears she acknowledged a life-long “worriment” that this wish of hers may have been the cause of her son's problems. The son, feeling almost well after this discourse, mused that he had the thought that he owed his life to this “good natured doctor.” I have described this case in more detail in a previous publication (Sonne 1994a).

"Swept Away In a Tidal Wave"

This patient's mother had had numerous miscarriages, some before the patient's birth, and some before and after the birth of her sister four years later. Although her mother had told her that there was nothing unusual about her pregnancy with her, the patient had read years later in her mother's medical records that the prognosis of the pregnancy was guarded. The patient's father was ill in the hospital during the late pregnancy, delivery and for several months of the neonatal period. During the mother's pregnancy with the younger sister, the patient was repeatedly told by her father to be quiet or she might cause her mother to lose the baby. If she were noisy, she was sent to her room and confined there with the door closed. She developed into a child who was openly defined by the family as mother's mother, and family and friends often commented that they were never able to know what she was feeling. She had a recurrent childhood nightmare of being swept away in a tidal wave, a dream which only occurred when she was away from home. Following this dream she would have to rush home to a presumed safety, only to then feel trapped in her home.

When the patient became pregnant with her first child, a miracle to her since she had assumed she was sterile because of prior ovarian surgery, her mother's response was, "How could you do this to me?" and insisted that she have an abortion. Although not married to the father of the baby, and married to someone else, the patient nevertheless happily continued her pregnancy, enduring diatribes from her mother, and weathering her father's divorcing her mother shortly before the birth of the baby. Her decision to continue the pregnancy was aided by a memory of a comment made by her younger sister, who had died of cancer six months before the pregnancy, that she always knew the patient would have a baby because she wanted one so much.

Four years after the birth of this child, this woman remarried, but the marriage was a disaster. She finally told her untrusting and controlling husband that after years of suppressing her feelings in the vain hope of reassuring him that he was loved, she felt as if she was buried, as if something had died. She said that she was gasping for air, drowning, and being forced into a corner. She protested to him that she had been transfusing him for years, and that now she had no more blood to spare.

"I May Have Felt Guilty"

The husband of the "swept away" patient probably had unresolved conflicts about abortion himself, which he was acting out, and the relationship between him and his wife is illustrative of the interweaving of abortion dynamics in the relationship of a couple, and in their parenting. When he married his wife he refused to accept the "evil" child she brought with her from her prior relationship, who, when I saw the family, impressed me as a likeable pre-teenager who was the sanest member of the family. At one point he expressed a fear that this child might kill him. When he was told by his delighted wife, a few years into their marriage, that he had fathered a child of his own, he immediately remarked that he didn't know whether he could handle it, and asked if he could go back to sleep. He had had two abortions in prior relationships, and wondered if he "perhaps" felt guilty about this. In effect,

he had performed a psychological abortion on his wife during their years together. He had threatened her that if she were to leave him, which she eventually did, it would only be over his dead body.

“Be Yourself”

This patient was conceived by two parents who were each married to someone else. He was adopted as a seven-day-old newborn by an infertile couple. He was underweight, and was overfed by his adoptive mother and swaddled in so many blankets that the pediatrician told her that she was going to kill him. He was told by her that he was an angel from heaven. As a three-year-old, while his mother was reading him a book about where babies came from, he had asked her “Where did *I* come from?” His mother answered his question by saying “I don’t know.” The patient stated his social phobia began after hearing this frightening statement. It also contributed to his having a life long reading disability for books but not for other written or printed material. In puzzling over his origins he became convinced, partly from seeing his adopted younger

brother picked up from a nursery, that babies were picked up like merchandise in a supermarket and could just as easily be returned if unsatisfactory. He developed into a frozen, quiet child, who was praised for his quietness as a “good baby.” Sometime into his analysis, when we were talking about how he tended to self-abort, both psychologically and literally, he suddenly recalled something he had never told anyone before. When he was six he had attempted suicide by eating some cleaning paste. He remembered every detail, the color of the can, the taste of the paste, and even the fact that his mother had made little of this episode.

He was told by his mother to “be yourself” whenever he spoke up or expressed an opinion or preference, particularly if he expressed an interest in girls, or they in him. When he commented on an interesting observation he had made of life around him, he was told that what he saw or heard, for example hearing his neighbor beating his wife, and being also told of this by the neighbors’ children, wasn’t true or could not have happened. When he would comment on the strange and abusive behavior of his father, who had had a stroke when the patient was three years old, his mother would deny that the father had anything wrong with him.. If he was partially believed about some things, this was often followed by a comment such as, “Only a person like you would notice something like that.”

“Smushed-up Unborn Babies”

This young man, in his third year of analysis, began to express a host of memories and fantasies about the dread of being aborted after making an analogy between an unborn baby and a touch sensitive mimosa plant he was going to let die because his sweetheart had abandoned him. He was going to abort the mimosa fetus. With his acquiescence, two of his actual offspring, one of which was conceived with this sweetheart, had already been aborted earlier. His mother had had an abortion prior to his birth, and he had exulted in the knowledge of this, for if this had not occurred he would not have been he as “the only one.” He had a dream in which he was feeding a gray, “smushed up” cereal-like material to a group of women on a beach, and associated to this that the material was smushed up unborn babies,

including himself, and that he was prepared to sacrifice himself and others in order to horrify the women, and also achieve an oral reunion with them. He had repeated dreams that he was going to be shot next in line in a gangster style execution, or that he would die in a rocket or airplane crash, feeling dread knowing that his death was imminent. He said that waiting in dread for five seconds would seem two months to an unborn baby. After a three month period in his analysis replete with prenatal associations, prenatal dreams, and prenatal transference material, most of it interpreted by the patient himself, this patient consolidated dramatic changes in himself, and terminated his analysis. During this period of revision and consolidation, while reflecting on whether he and other people have souls, he asked several of his associates if they believed they had souls. If they expressed doubts he would then shake them up by asking them if they would sell their possibly non-existent souls to him for a dollar. He spontaneously shifted his position on abortion from one of being decidedly pro-abortion to one of being decidedly pro-life. I have described this case more fully in a previous publication (1994a).

“You’re Only Alive Today Because the Bichloride of Mercury Didn’t Work”

This patient came to see me after repeated hospitalizations because of several suicide attempts. He was originally taken to the hospital when he abruptly said at work that he absolutely could not cope. One of his suicide attempts involved choking himself with a belt till his eyes bulged out. Another involved banging his head on a bathtub. A third interrupted attempt involved his taping up all the windows of the house with a plan to gas himself inside. He had been conceived on Black Friday, the day of the stock market crash in 1929. His father had been a well-to-do stock broker, and many of his clients who, like himself, had suffered extreme losses, were jumping out of windows. His mother attempted to abort her son at that time, and she repeatedly told him throughout his life that the only reason he was alive today was that the bichloride of mercury she had used in her attempt to abort him hadn’t worked.

On his wedding night he fell asleep without consummating the marriage. The day after the wedding he showed uncharacteristic repeated outbursts of temper, something which his wife had never seen during their courtship. He threw a tennis racket when she hit a lucky shot, and later threw a golf club. That evening, when they did have intercourse, it was mechanical, and he expressed a worry over what his mother might think of his leaving her to be sexual with another woman. He repeatedly stalled their having a child, saying he wasn’t ready. When they did have one he was extremely jealous, and one time threw their then eight day old baby across the room to his wife, who fortunately caught him.

“I Had My Hands Full With You”

The wife of the “bichloride of mercury” patient was also probably an abortion survivor, and the relationship between her and her husband is a further illustration of the enmeshing of abortion dynamics in the relationship between a couple, and in their parenting. She colluded in letting herself be cowed, and in effect psychologically aborted by her husband. She learned early on never to cross him,

and would intentionally lose when they played tennis. Notable in her history was the story she was told by her mother that when she was six months old the doctor had arrived at her home with a death certificate, only to learn to his surprise that she had rallied from a near fatal illness after an all-night massage from a loving chiropractor. She also revealed that her mother had had an abortion when she, the daughter, was about two years old. When she asked her mother years later why she had had the abortion, the mother had responded, "I had it because I had my hands full with you." Her mother had repeatedly told her that one should never give birth in a Catholic hospital, for if there is trouble the doctors let the mother die and save the baby.

"Basically Defective"

This woman had had many years of analysis with another analyst, whom she had begun to see shortly after having adopted a baby because she assumed that she was a carrier of a genetic defect inherited by her older brother. She felt after the adoption that she, in addition to the possibility of being a carrier, was also basically psychologically defective and unable to mother. Her unsatisfactory experience with this analyst confirmed for her that she was indeed basically defective. In fact she quoted him as having said that there are some things that perhaps she could never change. After several years of marital, family, and individual therapy with me, during which there were definite but limited gains, and during which she was resistant to entertaining the operation of abortion dynamics in her life despite my gently and repeatedly broaching them, she abruptly left her husband. She also wrote me a letter stating that she was discontinuing therapy because I had utterly failed to understand how she had been totally invalidated by her husband in her marriage. Her departure had been precipitated by a strong ultimatum from her previously passive and passive aggressive husband, that he would no longer tolerate his own needs not being met. I did not call her, and her husband and I continued to meet in her absence. I told him my formulation of what I thought the abortion dynamics were that were being acted out by his wife, who, in addition to being angry at him and me, was expressing a smouldering resentment toward her mother and her mother-in-law, making such statements as not having a space for herself, and being unable to claim her home her own.

I shortly received a phone call from the husband telling me that his wife had come home after spending a week alone in a motel. She had told him that she loved him, that she wanted their marriage to work, and that she wanted to continue therapy. He added that she had become incredibly warm and sexually responsive. At our next couple session together, I interpreted to her that it seemed to me that what she had been doing was an attempt at self aborting, and that she had been acting out in the transference in her marriage, and in the transference to me, her reaction to her mother's not having wanted her, and not having cared for her. I reminded her that her mother had told her that she had not wanted to have her, and that she had become pregnant against her wishes only because her husband was insistent and had forced himself on her. We had speculated in the past that part of her mother's reluctance to have her was out of fear that she might have a second genetically handicapped child. Regardless of the possible reason, the mother had in fact not wanted her. She had also turned over much of her daughter's care to

the father and relatives during the postnatal period, professing herself to be totally incompetent as a mother of a newborn. What her mother was afraid of, and what she may have masochistically needed, was what she got, another defective child. Her daughter was afraid to be whole, and complied by regarding herself as basically defective her entire life, even though she was highly competent in many ways. Although this patient had previously resisted all attempts to encourage her to consider abortion dynamics, at this juncture in therapy she accepted my interpretation and changed markedly. She related more lovingly to her husband thereafter, and to me, in a warm and happy way that was distinctly visible in the therapy sessions, which had an ambience replete with tenderness, patience and smiles. Although in the past this patient had strongly defended a woman's right to abortion, she said in one ensuing session near termination, during which both she and her husband were enthusiastically discussing a current paper I (Sonne 1995) was working on entitled, "Prenatal Themes in Rock Music," that for a mother to want to abort her own child was the most hostile wish a mother could have, and the ultimate in not caring. She was no longer overly distressed by difficulties arising in her work, or with her now grown adopted children, that had in the past almost incapacitated her. She spoke of feeling involved and affected, but at the same time independent, separate and secure. The couple's almost non-existent sex life improved as she began to passionately enjoy love making, and within a month both she and her husband jointly decided to decrease the frequency of their sessions and shortly stopped therapy altogether.

The Psychological Family

Not the mother alone, but the father, the total ambient psychological family, the therapeutic community, and the wider social milieu are all important determinants in both the causation of prenatal trauma, and its healing or reinforcement in postnatal life. If the prenatal family is not what I have called a psychological family it not only does not provide the unborn with the ingredients necessary for him to begin to construct a family image in utero, but it will also be unlikely to provide him with these ingredients postnatally. The psychological family is the external representation of the internalized family images its members have constructed from successfully living through heterosexual triadic family experiences in their families of origin over time. (Sonne 1990, 1991). Whether the prenatal family is a psychological one or not is obviously greatly dependent upon multigenerational influences favoring or crippling its optimal construction and maintenance.

The Abortion Survivor's Mother

The sentimental way mothers who have attempted to abort their unborn often relate to their child once he is born is an important phenomenon to examine. Some of this is also seen in adoptive mothers. Although these mothers ignore their children in certain respects, they are nevertheless often incredibly focused on them, and give the appearance of being devoted mothers. The "you were only a period" mother started saving for her son's medical school education the day he was born. The "bichloride of mercury" mother wrote her son adoring love letters, and he

seemed to be the center of her life. The “hands full with you” mother brightened up whenever her daughter visited her. The mother of the “tidal wave” patient lived and breathed for and from her daughter. The mother of the “smushed up unborn babies” patient sought advice from her son about important matters more than she did from her husband. The “be yourself” adoptive mother made her son the center of her life, and kept telling him what a wonderful young man he was, all the while negating his curiosity and his individuality.

The mothers are often sacrificially attentive and do extraordinary things for the survivor. Sometimes they seem to say the right thing, such as the “Oh, no!” mother saying to her daughter that she shouldn’t feel guilty because she hadn’t done anything. This was actually double talk, since the mother had already conveyed to the daughter in many ways that she had in fact done something wrong by being conceived and coming into the world. All of this is very confusing to the abortion survivor, who looks at things such as this as love and wonders why he isn’t happy. What goes unnoticed is that the mothers are giving to the child mostly in terms of what they want to give him, less in terms of what the child needs, and that they lack empathy. They are metaphorolytic, take the meaning out of life, and tell the children how they should feel. They often act like amateur psychoanalysts, interpreting their child’s behavior “for the child’s benefit,” and patients often come to therapy already idiosyncratically “psychoanalyzed” by being told what is wrong with them by their mothers. This can make matters difficult for the professional analyst next in line. These mothers seldom say that they are sorry, or that they were wrong about anything, or that their child was right about anything. They can be using the child for their own needs even in an act of seeming generosity. In effect, they are treating the child as if he were their property or a part of their body, the same way they treated him when he was in utero. The proof of this can be seen in instances when the child attempts to express independent thoughts, feelings or behavior that are not in line with what the mother wants, and the mother responds by invalidating him through subtle dissuasion, seduction, sudden harshness, tears, or the threat of abandonment.

The origin of the mothers’ excessively attentive postnatal behavior would seem to come partially from a restitutive need to undo the guilt associated with their sense that they may have damaged their child in utero by their abortion attempts, as with the “worriment” mother of the “only a period” patient and the “only reason you’re alive today” mother of the “bichloride of mercury” patient. The mothers’ proclivity to see their child as defective at the slightest sign of deviance from their own standards, and their continued postnatal psychological abortion threats, also suggest that they may be thinking that they were wrong not to have aborted him, and that perhaps he should still be aborted today because he has been so damaged as the result of an incomplete abortion. The mothers’ postnatal ambivalent behavior keeps the abortion survivor hopelessly trapped and confused. He reads and copies his mother’s message to him that he is inherently defective or irreparably damaged. He should be grateful that he was not aborted. He is an accident, a non-bona fide family member who is accepted under sufferance, and he continues to live with the threat of abortion. All of this induces low self esteem, fear, self abortion wishes, and a contrasting accompanying sense of special entitlement to reparations. He is being simultaneously psychologically aborted and

psychologically confined, an abortion equivalent. It is important for the analyst to understand the mothers' dynamics and postnatal interaction with her child if he is to help his abortion survivor patient see through it, and help the mother as well.

The Abortion Survivor's Father

Many fathers of aborted children or abortion survivors were not even consulted or informed by the mothers of their abortions or abortion attempts. If they are, and wish to have the child, many are hesitant to disagree with their mates. One father, whose sweetheart had two abortions prior to their marriage, expressed his belief that it would have been wrong of him to have interfered, for it was her right to decide whether or not she wanted to have the children. Some fathers indifferently leave it to the mother to do as she wishes. Some send a message implying that they wish their offspring had been aborted. For example, the father of the twin "magic baby" patient blamed his daughter for her birth having caused his wife's mental illness.

Protecting the child and confronting the mother prenatally and postnatally is something the fathers of abortion survivors seldom do. Dependent on their wives or lovers, and competitive with the unborn, the fathers do not function as protectors of physical and psychological life, and collude in or encourage the mothers' destructive behavior to the detriment of themselves, the mothers and the children. It is thus very important for the analyst to be receptive and affirming of abortion survivors' thoughts, feeling, observations and opinions in most matters, even though many of them are critical and negative, and to support their right to have a life and pursue happiness. Their problem is not with their perceptions, it is with their masochism, their self doubt, their tendency to be selectively preoccupied with the negative, and in their difficulty in letting themselves be loved.

The Significance of Parental Ambivalence to the Unborn

The seemingly universal acceptance that ambivalence about a pregnancy on the part of many mothers and fathers is natural and understandable masks the fact that ambivalence contains within it a conflicted wish to abort the fetus, the little one, and a denial of the possibility that this ambivalence is registered in the memory of the unborn. For the trusting and vulnerable unborn there can be no ambivalence on the part of his father or mother, for to the degree he hears it, feels it, and experiences it, to him it represents a hovering sense that he is an unwelcome intruder who is not being happily cared for, and that there exists the imminent possibility that his life may be abruptly interrupted at any moment. If we socially accept as normal an ambivalence in pregnancy that we would define as psychopathological elsewhere, as in schizophrenia or in instances of developmental arrest for example, we are closing our minds to considering the impact of the hostility inherent in this on the fetus. The ambivalence here is not about a trait or a behavior, about being pregnant, or about the feelings of the mother or father about themselves or one another, it is about the unborn's existence or non-existence. It is aimed directly at the unborn, whether it is characterized as such or not.

I have written elsewhere on the subject of resistances to exploring prenatal experiences, particularly prenatal trauma, that are operative in society, in the helping professions, and in individuals, and have speculated on their possible causes, among which is a fear of examining their own dread of being aborted and not examining their own ambivalence (Sonne 1994b). Those in the

helping professions who tend to discount vague descriptions of intrauterine traumatic experiences as fantasies are open to the challenge that they, like abortion survivors, are similarly using repression, denial and wish fulfillment fantasies. The fantasy that intrauterine life is blissful is a very common one, however DeMause (1982) has well documented that intrauterine life, even under ordinary circumstances, is by no means the tranquil, idyllic one it is so often imagined to be. Add to this universally experienced intrauterine travail the fact that 25% of pregnancies are intentionally being aborted worldwide (Sonne 1994c), and one can see that any personally felt dread of being aborted expressed by those who have partially survived the threat of being aborted, is in fact being reinforced by a grounding in a current ambient threatening social reality, and is quite realistic, despite the fact that this threat tends to be discounted by many as an unrealistic or unrememberable fear.

Suicidal and Homicidal Impulses in Abortion Survivors

As mentioned earlier, abortion survivors' behavior in life is such that they repeatedly experience, are very vulnerable to and almost invite, being psychologically aborted. They have identified with the ambivalent aggressor, and are inclined to psychologically abort themselves. This diathesis can be seen in a direct wish to have been aborted, and in adult suicidal ideation. The mother who wanted the doctor to "bring on her period," said that she wouldn't have minded having been aborted, for her life had not been all that happy. She had often had the impulse to jump out of a window, an impulse also felt by her abortion survivor son. She said that her mother had had too many children, she being one of the too many, and if she had been aborted, perhaps her mother might not have died giving birth to her youngest sibling. This self-aborting wish and behavior is commonly seen in abortion survivors, although most of them are unaware of the origins of their behavior. Feldmar (1979) studied four suicidal teenagers, whose annual suicide attempts occurred on the anniversaries of the dates at which their mothers confirmed that they had attempted to abort their daughters. The daughters were unaware of the connection between their suicide attempts and the fact that they were abortion survivors. Ferenczi, in his paper, "The Unwelcome Child and his Death Instinct," written decades ago (1929), dealt at length with the connection between being an unwanted child and not only an aversion to life but also a desire to die. Although Ferenczi did not discuss abortion, his findings are supportive of the thesis of this paper that we need to interpret the dread of being, and the wish to be, aborted, in the therapy of unwanted children, who in essence are abortion survivors.

Abortion survivors do not only have suicidal wishes. They also have homicidal wishes which can be expressed in acting out by aborting their own offspring, or by sanctioning and promoting the abortion of other unborn children, as with the

“smushed up unborn babies” patient who said that there were too many people in the world. Such dynamics may well be operative in some adult murders.

Grounding in God, Generational Genetics, and a Gang

Abortion survivors, even when they examine the impact of their prenatal experience on their lives, sometimes see their parents as such powerful determinants of their self definition, that they may still consider themselves to be permanently damaged. It is helpful to ask an abortion survivor, who often does not believe in God, whether he ever considered himself to be one of God’s creatures, and to ask him also, since he often considers himself to be genetically flawed, if he ever thought about the fact that his genetic endowment came from countless past generations. These two ideas can help him to feel in touch with his soul and spirituality, and can help him to feel a sense of continuity with his roots in a long line of ancestors. This can help free him from reliance on his parents as such powerful determiners of his self definition. His parents can then be seen merely as agents and carriers, particular human beings at a particular time, who conceived him, brought him into this world, and raised him. Neither parent has the right to redefine his genetic expression, and neither parent is God. These ideas can help the patient to re-examine his conclusions about what his true self is, to believe there is a true self within him, to claim his right to live physically and psychologically, and to minimize the distorting power of his experience with his parents, who may for a variety of reasons have been unable to communicate to him how wonderful he is, and to facilitate his life blossoming. Many abortion survivors, upon resolution of their abortion dynamics, find themselves attending religious services for the first time in years. They become interested in searching out and communicating with extended family members, including great aunts and uncles and distant relatives, and become interested in their geneological history for several generations back. They also simultaneously experience a marked diminution in their hostility toward their parents, and an improvement in their relationship with them. Their relationship with their children improves, and there is either an improvement in their marriages or a separation.

In addition to suggesting to abortion survivors that they might reflect on God and genetics in their search for a true self, I will occasionally suggest a third grounding idea, that they need to find themselves a gang in their social milieu. Along these lines, when they describe themselves enjoying affirmation in the wider world of man, even if it is with an almost complete stranger with whom they momentarily feel a kinship, I will underscore how significant an experience this is for them despite the fact that they might find the feelings they have novel and strange. These affirming encounters are experiences of the true self, not of the false self that was acted out, for example, by the “be yourself” patient in obedience to his mother.

Handling Parental Guilt and Shame

When abortion-minded parents are ready to drop their defenses and their sentimentality, the handling of guilt over having aborted a child, or having wanted

to, is an important issue for the therapist to think about and deal with in working with parents. Their responsibility cannot be brushed away by the therapist colluding by suggesting that they should not feel guilty. To do so leaves the guilt not processed and still operative underground. They have to struggle with it or they won't be able to grieve or love. I don't disagree with parents when they say they feel guilty, but I do not condemn them. I try to help them to deal with this guilt without total self condemnation or exoneration. They need to recognize that their own guilt and shame about their own existence and worth, their dread of being aborted themselves, and their suppressed rage at their parents all played a role in their acting out. With the "magic baby" twin mentioned earlier, for example, I helped her deal with these feelings. She was able to face squarely the fact that she had not provided adequate mothering to her children. Crippled as a child herself, and an abortion survivor, she had been totally overwhelmed as a wife and mother. I pointed out to her that there were many variables involved in her relationship with the daughter who had the abortion and the daughter who committed suicide. I reminded her, as mentioned earlier, that she was not God, and that she was not alone. Her suicidal first husband, her suicidal family of origin, her suicidal extended family, her daughters' unique capacities and decisions, and the friends they chose all bore some degree of responsibility for the tragedies in her family.

Abortion Dynamics in Adoptees

It is especially important to keep abortion dynamics in mind when working with adoptees. That they have more psychological problems than do non-adoptees, particularly with identity issues, has been well documented by Schecter (1960). It is a safe assumption that mothers and fathers who give up their child for adoption were ambivalent about their unborn, and that these impulses were communicated to him in utero. The prenatal period may have been replete with emotional turmoil on the part of the parents and their families, and adequate physical prenatal care may have been lacking. It is important to keep this in mind relative to clarifying the adoptee's postnatal feelings of abandonment, his identity issues, his continuity issues, and his adoptive family relationships.

It is not only important for the analyst to think about the adoptee's prenatal history, it is important for him to also learn of what the adoptive parents thought about their adoptee's prenatal experience, and how they may have described it to him. If the adoptive parents reject, distort, or refuse to recognize the adoptee's birth parents' contribution to the adoptee, a contribution which would include, for better or worse, both his genetic endowment and his intrauterine experience, they are in effect not recognizing the uniqueness and continuity of the life of their adoptee. If the heritage from the birth parents, who in effect are a part of the adoptive family, is denied, then it is not incorporated or processed during the development of the adoptee's identity.

The "be yourself" patient, who was told as a toddler by his adoptive mother that she didn't know where he came from, had an additional experience with his adoptive family that further distanced him from his origins. He had displayed a talent with the trumpet as a teenager, and his paternal grandmother had once made a passing remark that he may have inherited this musical talent from his

birth mother or his birth father. Witnessing his adoptive mother's displeasure upon hearing such a speculation told him decidedly that she did not want to recognize that he had been conceived by a mother other than herself and by a husband other than her own. He obliged her by quietly giving up his trumpet, and subsequently would not let the repeated loving efforts by any of his grandparents to encourage him in music, or in sports as well, have any effect on him.

During his analysis, and his search for his roots, he learned from the adoption agency that his birth mother's story to them and to her family had been that he was the product of a rape. He learned the truth of his conception from his birth father and from his maternal and paternal siblings. When he tried to contact his birth mother she refused to see him, and her husband called him to tell him that they had considered aborting him once and that it wouldn't be all that difficult to get rid of him today. Although his birth mother's family knew of her pregnancy with him, they had been told of his birth that he had been stillborn. He needs to hear from his birth mother whether she did try to abort him, and he wants to learn of his ancestry generations back.

Increased Warmth and Poetic Language upon Recovery

Upon resolution of the dread of being aborted, and the resumption of "going on being" (Winnicott 1949), abortion survivors often show rather rapid and dramatic changes in thinking, feeling and behavior. One of the most noticeable changes is in their affect and in their use of language. They display more affect, more humor, and begin to understand and use more metaphors, metonyms, synesthesia, and polysema, whereas their prior language had been dry and colorless. The "smushed up unborn babies" patient, and the "only a period" patients described earlier, both of whom had previously been cold and "logical," became much warmer and much more poetic. The "smushed up unborn babies" patient began writing poems, and the "only a period" patient became more the poem he had always wanted to be in his feeling and in his use of language.

The "be yourself" patient said that he felt tender and sad upon reading this current paper. Tears came to his eyes. He said that he had never completely understood, even with all his analysis with me, how fundamental, basic and groundbreaking the concepts were, and how much they applied to him. They were much more important than castration anxiety. He shook hands firmly at the end of the session, whereas he had previously been averse to touching or being touched. The day after reading this paper he took a three hour drive to visit his birth father, the second time he had seen him since his first contact with him five years ago. When he saw his father, now in nursing home, he said, "I saw myself in my father's eyes." The more recent nursing home personnel were surprised to learn that his father had a second son, but one older nurse told him that whenever his father saw a little boy he would weep and talk about "the other one," and she had known what that meant. There was color in the patient's face as he told this story, more timbre in his voice, and when I told him at the end of the session that I would miss him while I was away to present this paper at a meeting, he quickly and warmly responded, again firmly shook my hand, and said, "And I'll miss you too."

When the “magic baby” twin gradually felt less masochistic and more entitled to live and enjoy life, she mourned her losses, and became comfortably creative. She became physically healthy, lost weight, and stopped drinking excessively. The changes in her as she claimed recognition as a healthy, individuated person, changed her siblings and her family of procreation. She helped the daughter who had had the abortion deal with her guilt, resolved her difficulties with her twin brother, whom she laughingly told me “didn’t know that not too long ago I was talking in therapy about wanting to kill him,” and fought her way into a healthy relationship with her second husband. Today she is an absolute delight to be with, bouncy, creative, incredibly poetic and descriptive in conversation, responsive, disciplined, loving, and productive. She enjoys her work, her more loving husband, her two surviving children, their spouses, the three grandchildren she frequently sees, and she gains pleasure from hearing occasionally from his adoptive parents that her fourth grandchild, her deceased daughter’s now adopted child, is doing well.

Being Open to Hearing the Dread of Being Aborted in Therapy

One might argue that all of the above examples are not proof enough that these patients had suffered an intrauterine trauma. It is difficult to establish proof, truth and fact in any historical reconstruction in any field of study, for example in archeology, evolution, the origin of the universe, or in the reconstruction of a crime. This is particularly true in psychological reconstruction, where one must draw inferences, not only from the patient’s history, but also from symbolic or metaphoric expressions, affect, body language, unusual speech patterns, unusual colorless use of language, nuances in the patient’s behavior toward the therapist, his manner of relating to the therapist’s office, his chairs, his couch, his door, and repeated descriptions of abortion-like experiences in everyday life. The abortion survivor may dread the couch, lie frozen on it, sit immobile in his chair, or not make eye contact. I have particularly perked up my ears when a patient firmly closes the door to my consultation room upon leaving. When I asked the “be yourself” patient about his doing this he said that the consultation room was private, and that he wanted to be sure that nothing fell out. The “smushed up unborn babies” patient had associations that my consultation room was the uterus, and the waiting room the vagina. He said that the pressure in the consultation room was decidedly higher than outside. He developed an acute hypersensitivity to any outside sounds, and kept asking himself the question, “Why is the sky blue?”

The meaning of the messages communicated to the traumatized unborn, and the symbolic messages communicated by him, are “known but unthought” (Bollas 1987) by the patient until the associative links are interpreted in therapy. Such interpretations require the therapist to think in terms of prenatal mentation and communication, and to consider the dread of abortion as a possible component in the transference and in common syndromes that traditionally have been viewed and interpreted as primarily having a post-natal origin. Failure to do this may result in an interminable or unsatisfactory therapy. Discovery comes to the prepared mind, and one must be suspicious in order to hear and interpret the veiled descriptions of the unborn’s experience. Even an abortion survivor who has a scar

on his head from an attempt by his mother to abort him with a coat hanger may have difficulty literally describing with feeling a prenatal experience that occurred prior to his ability to use language in thinking and speaking. Patients do not rush into the consulting room bursting to tell their analyst about their prenatal trauma. It is painful to talk about, and they don't want to do it. Nor do I. Hilda Abraham (1969) has suggested that the paucity of attention paid to the psychology of unwanted pregnancy in the psychoanalytic literature suggests an active wish among psychoanalysts *not* to think about it. Her talk focused on the psychopathology of pregnant mothers, not so much on the fetal experience, as did my early papers on "Feticide as Acting Out," (Sonne 1966), and "Pregnancy, Abortion and the Unconscious," (Sonne 1975). It is only in more recent years that there has been a focus on the fetal experience, and it is even more recently that there has been a central focus on the fetally experienced dread of being aborted.

The Dread of Being Aborted as a Clarifier

Although a variety of etiological explanations for many psychopathological syndromes can be deduced, no other theory so comprehensively explains such a wide spectrum of syndromes as does the dread of being aborted. A unifying theory of causality that fits the most facts is generally considered to be the most plausible one. If one links the fear of being smothered, drowned, poisoned, trapped, or caught in a tunnel or a cave, with intrauterine experience, it is relatively easy to link this as a precursor epigenetically linked with similar experiences at the breast, but it is more difficult to retrogenitically link experiences at the breast as a causal explanation for traumatic experiences at an earlier time. The dread of being aborted explains more than does the fear of annihilation at the breast, or castration anxiety, and in fact helps explain these later fears. For example, the nursing dream of the "Oh, no!" patient who liked nests, and whose mother had had several abortions, could be interpreted in terms of orality, but knowing the history and other material, one would also interpret it as containing a dread of being aborted, a screen memory of sorts.

The Dread of Being Aborted and Sexual Inhibition

Even anxiety or inhibition relative to sexual intercourse is more richly explained if one considers that sexual intimacy and orgasm could stimulate subliminal primitive memories of one's own conception and could revive fears of traumatic intrauterine experiences involving the threat of death, not just castration. Bion (1977), who was very interested in what he called the fetal proto-mind, has speculated that marriage and sexual intercourse provide an opportunity for the reworking of intrauterine experience and the caesura of birth and their integration into current life. Reflecting on this, it would seem to be easier to understand this experience for men than for women, for men penetrate women in two directions, once from the inside to the outside during birth, and then from the outside to the inside during sexual intercourse, and thus experience a re-enactment of sorts of the fetal sense of being inside or outside the womb, with its inherent fears, but women can also experience a re-enactment of sorts of the fetal sense of being in

or out of the womb. They can fear being intruded upon, or in effect feeling in their unconscious that their fetal self may be “aborted” by penile penetration. Aside from fears coming from the unconscious, many women, and men as well, are consciously afraid that having intercourse during pregnancy will harm the baby. Although women can hold and release the penis, they can also fear being abandoned by it, another form of “abortion.” Ejaculation and orgasm usher in a potential recapitulation of conception in the unconscious of both partners, again with all the wishes and fears associated with this. An example of fearing being inside of mother’s body was seen in the male patient whose mother kept telling him to “be yourself.” He said that he had never, prior to his analysis, ever thought a single thought about the fact that at one point in his life he had been inside of his mother’s body. When he did think about it, it was frightening to him. The very idea was repugnant to him, and the thought of the fluids in his mother’s body was abhorrent. He triumphantly and emphatically absolutely relished the feeling that no woman could ever have control over him, get her hooks in him, or catch him with her vagina and entice him to enter her. When in a more positive mood he realized that he had loved his birth mother in utero, and that his aversion to women was in large part a reaction to her not having fully loved him, as well as a reaction to his adoptive mother’s controlling behavior. When in this mood he wanted to be able to surmount his dread of being aborted and safely feel the desire to have intercourse with a woman who loved babies and loved men.

The Proof of the Pudding

A point to bear in mind in regard to interpreting the dread of being aborted is that one test of a theory is whether it works when applied in action. A close friend and colleague, James Grotstein, wrote me that after reading my papers on the relevance of the dread of being aborted (Sonne 1994a, 1994b), he had explored the possibility of this dread with a patient who had been in analysis with him for fourteen years (Grotstein 1992). This exploration dramatically brought out a previously unexpressed belief of the patient that her mother had wanted to abort her. More importantly, it also brought out the patient’s dread of being aborted in therapy, which had been a previously unmentioned but conscious component of the transference. The patient told Doctor Grotstein that she had always believed that he, himself, her analyst, also “wants to abort her.” Another colleague, Victor Schermer (1995), told me of his experience with a mother and her eight year old daughter. When he spoke to them of my work, after hearing that the mother had been beaten by her husband during her pregnancy, the little girl immediately brightened up, showed great interest, and exhibited a marked change in her behavior.

It has been my experience that several patients who had had either long analyses with other analysts, or with me, even though they had uncovered and had interpreted many self-object and psychosexual conflicts centering around various postnatal experiences, did not start to really move, or feel present and alive, until abortion dynamics entered the therapeutic theater and were interpreted, particularly in the transference. Some of these abortion survivors had experienced a psychological abortion in prior therapy, resulting in either an interminable analy-

sis, a psychological abortion in the form of a premature termination of the therapy, or had attempted a literal self-abortion in the form of suicide. Traditional theories of psychogenesis are indeed incomplete and unsatisfactory explanations of much of the psychopathology we see, and much that happens in the transference and countertransference. If more therapists could open their minds to hearing and thinking about the dread of being aborted, they might see for themselves what happens when this is introduced as a clarifying variable in their work with individual patients, couples and families who are struggling with issues of identity, survival, suicide, divorce, abortion, adoption, lack of affirmation, child abuse, and other psychopathological complexes, that have not been modified by postnatal interpretations.

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