

Isolation, Rejection and Communion in the Womb

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Abstract: Most people whether they be lay people, scientists or academics cling to a whole slew of erroneous beliefs about prenatal life. Two of the most prevalent ones are: first, that the uterus is a place of perfect peace, harmony and joy and second, that our mental faculties start to develop only after birth i.e. that babies prior to birth are mindless creatures. Why this stubborn resistance when evidence to the contrary is so overwhelming? I think it is due to the presence of a collective unconscious defense against the threat of re-stimulating and reawakening deeply repressed feelings of intrauterine rejection, isolation and separation. Even a person who as a pre-nate had miraculously escaped exposure to any toxic maternal or paternal feelings would find re-experiencing this state of prenatal bliss, compared to his present existence, painful. In other words, no matter whether you had a good or a bad pre-natal life, you don't want to be reminded of it. On the other hand, those attending this Congress have, in various ways, done their work, faced and overcome their fears and now, are willing to look at the facts. One of these facts is that unborn children respond to and are affected by maternal emotions. This paper will attempt to examine those maternal feelings and attitudes that promote the formation of a strong ego and a healthy mind-body continuum and those that create feelings of dejection and despair in the unborn. We will examine the effect of parental messages on the unborn and newborn and not the mechanisms of parental fetal communication, a subject I have dealt with previously (Verny and Weintraub 1991; Verny and Kelly 1981). Our focus will be on negative parental fetal communication though the effect of positive prenatal parenting will also be briefly studied.

Zusammenfassung: *Isolation, Zurückweisung und Verbundenheit im Mutterleib.* Die meisten Menschen, seien es nun Laien, Wissenschaftler oder Akademiker, haben eine ganze Reihe von irrigen Annahmen über das vorgeburtliche Leben. Zwei besonders häufige sind: Erstens, daß der Uterus ein Platz vollendeten Friedens und von Harmonie und Freude sei, und zweitens, daß unsere geistigen Fähigkeiten sich erst nach der Geburt entwickeln, d. h. daß Babys vor der Geburt geistlose Kreaturen sind. Warum nur dieser hartnäckige Widerstand, wenn die Beweise für das Gegenteil so überwältigend sind? Ich glaube, der Grund hierfür liegt in einer kollektiven unbewußten Abwehrhaltung gegen die Gefahr einer Wieder-

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erregung und Wiedererweckung tief verdrängter Gefühle intrauteriner Zurückweisung, Isolation und Getrenntheit. Sogar jemand, der vorgeburtlich das Glück hatte, keinen toxischen mütterlichen oder väterlichen Gefühlen ausgesetzt zu sein, würde ein Wiedererleben des vorgeburtlichen Zustandes im Vergleich zu seiner jetzigen Situation als schmerzhaft empfinden. Mit anderen Worten, unabhängig davon, ob man eine gute oder schlechte vorgeburtliche Situation hatte, will man nicht daran erinnert werden.

Nun haben sich die Teilnehmer dieses Kongresses auf unterschiedliche Weise hiermit auseinandergesetzt, haben sich ihren Ängsten gestellt und sie überwunden und sind nun bereit, sich mit den Tatsachen zu konfrontieren. Eine dieser Tatsachen besteht darin, daß das ungeborene Kind auf die mütterlichen Gefühle antwortet und durch sie bewegt wird. Dieser Artikel unternimmt es, die mütterlichen Gefühle und Einstellungen, die die Ausbildung eines starken Ichs und einer gesunden Leib-Seele-Kontinuität fördern, zu untersuchen, und ebenso die Gefühle und Einstellungen zu erfassen, die im Kind vor der Geburt Niedergeschlagenheit und Verzweiflung auslösen. Wir wollen die Auswirkung elterlicher Botschaften auf das ungeborene Kind und den Neugeborenen bestimmen und nicht die Wege der Kommunikation zwischen Eltern und vorgeburtlichem Kind untersuchen. Diesen Fragen sind wir an anderer Stelle nachgegangen (14, 15). Unser Fokus wird dabei die Auswirkung negativer elterlicher Gefühle und Haltungen auf das ungeborene Kind sein, wenn auch die Auswirkung positiver vorgeburtlicher elterlicher Einstellungen kurz untersucht wird.

Pollutions of the Amniotic Universe

There are many ways in which future parents and pregnant parents expose themselves, and in turn, their unborn children, to a variety of noxious and potentially harmful influences. Briefly stated, these toxins fall into two categories: External Toxins and Internal Toxins.

External Toxins

These are produced by agents outside the bodies of the parents and may be listed as

1. Environmental toxins and radiation.
2. Psychoactive drugs, hallucinogenic substances, tobacco and alcohol.
3. Obstetrical tests such as amniocentesis, chorionic villi sampling, ultrasound and many others.

The question arises: How much conscious control do parents have in this area? It is my belief that they have a lot, either by choosing to be addicted, or by choosing to ignore information about the detrimental effects on the baby of such things as radiation or amniocentesis.

Because of time limitations this paper will only deal with the second category, that is, the internal toxins.

Internal Toxins

By internal toxins I refer to a variety of neurotransmitters, stress, and sex hormones as well as thoughts, feelings, and behaviors produced by the pregnant mother and her partner. In the following section, I will focus on the quality of parental messages and their effect on the unborn and newborn and not on the mechanisms

of parental-fetal communication, a subject (Verny and Weintraub 1991; Verny and Kelly 1981) I have previously dealt with. I should point out that I consider human beings as mind-body entities so that every thought and feeling is both a mental and a physical phenomenon. Every hormone or chemical in our bodies is produced either in response to some mental representation or feeling state, or, once produced, induces an effect on the psyche. Consequently, a pregnant mother who bombards her baby with stress hormones is sending a certain message to her baby as is the mother who has a persistent pre-occupation with aborting her baby or who wishes that her baby were a male child. With this in mind, let us turn our attention to some extreme forms of parental-fetal toxic communication.

Consider for a moment the Greek myth of Oedipus. Oedipus was the son of Laius and Jocasta, King and Queen of Thebes, respectively.

After Laius married Jocasta, he was informed by the oracle that he will perish by the hands of his son. To prevent the fulfillment of the oracle, he decided never to approach Jocasta sexually. His solemn resolution was violated in a fit of intoxication induced by the Queen. The Queen became pregnant, as was her desire. Laius, still hoping to avert the evil, ordered his wife to destroy the child at birth, if it was a boy. Upon birth, the mother gave her newborn to a domestic with the instruction to expose him to the elements. The servant suspended the baby boy by the heels from a tree on Mount Cithaeron. There a shepherd found him and took him to Polybus, King of Corinth, who childless, raised him as his own and called him Oedipus.

Freud's interpretation of this story concentrates on Oedipus' unconscious wish to be intimate with his mother and to kill his father. Yet, in the actual myth, young Oedipus, on being told by the oracle of his fate, tried strenuously to avoid it by leaving Corinth. Freud makes no mention of this, or of Laius' fear of having a son. But most importantly, he does not make it plain that Oedipus' real parents attempted to kill him (Taylor 1988).

If Freud had allowed himself to pay more attention to the events leading to Oedipus' birth then perhaps he would have defined the Oedipus complex more correctly as belonging to a person who, exposed to rejection and abandonment by both parents pre- and post-natally, exhibited severe sexual abnormalities and murderous rage as an adult.

When you consider the fact that Jocasta must have been ridden with anxiety and guilt during the time she carried Oedipus, I think it stands to reason that he would have been severely traumatized in the womb. If we were to represent on a graph intrauterine experiences as going from the truly blissful to the most toxic then surely, at the negative end of this spectrum, from a psychological point of view, are babies whose mothers wish to abort them. What happens to babies who survive such wishes by their mother? (Bustan and Coker 1994) Research from Finland, Sweden and Czechoslovakia is instructive in this respect. Blomberg (1980) observed that all the differences in his study (which is the Swedish study) were uniformly to the disadvantage of the unwanted children. In the Finnish study, which is still continuing, the incidence of infant mortality, cerebral palsy and mental retardation was significantly higher among the unwanted children than the controls (Myhrman 1986).

The Prague cohort follows the development of 2290 children born in 1961–1963 to women twice denied abortion for the same pregnancy and pair-matched

controls from age 9 through ages 21–23. An excellent and thorough discussion of this research may be found in the book *Born Unwanted – Developmental Effects of Denied Abortion* by David, Dybrich, Matejcek and Schüller (1988). All the differences noted were consistently in disfavor of the unwanted children. Over the years, these differences widened and many that had not been statistically significant at age 9 became so at age 16 or 21. The findings of the Prague study and also of the Scandinavian research support the hypothesis that children rejected prenatally will, more likely than controls, show developmental, psychological and social handicaps.

In a paper published last year, Ann Coker (Bustan and Coker 1994), an epidemiologist from the University of South Carolina found that infants born of unwanted pregnancies are more than twice as likely to die within a month of being born than wanted children. The group studied were married, largely middle income women who were all receiving prenatal care. Low birth weight or congenital anomalies were not found to be factors in this study.

A study at Wayne State University (McIntosh, Roumayah and Bottoms 1995) of close to 15,000 singleton live births showed that mothers with broken marriages have a higher incidence of low birth weight infants than comparable groups of married or single mothers. This was attributed to poor fetal growth because preterm birth was not increased.

Apart from a conscious wish for an abortion, pre-natal rejection can also occur unconsciously for a variety of reasons and find expression in a number of ways.

One such condition is the denial of pregnancy by an otherwise healthy and “normal” woman. Brezinka (Brezinka et al. 1994) from the University of Innsbruck reports on 27 women who professed they did not know they were pregnant until term or until contractions set in. In this group, there were 4 fetal deaths, 3 premature babies, 1 case of intrauterine growth retardation and 1 case of possible intended infanticide. Obviously, these outcomes are grossly abnormal.

The following case study illustrates some of the salient features of a denied pregnancy (Wulfert 1986).

This pregnant woman was raised by a mother who didn’t want to be a mother. The subject stated that her mother was always “youth conscious” and she never told people she had a daughter. When her daughter became pregnant the mother refused to talk about it because she didn’t want to be a grandmother. All of the subject’s life her mother said to her “I doubt if you’ll ever get pregnant.” (The subject rarely had a menstrual period and even her doctor was convinced she wouldn’t be able to get pregnant. Yet she did.)

Three days after her expected due date the baby had not arrived. The subject informed this researcher that she wanted the baby to be late by four weeks so she could receive more money for her maternity leave. Fifteen days after the expected due date the doctor tried to induce labour, giving her pitocin for six hours. Nothing happened.

Twelve days later in the hospital, pitocin was given intravenously for 14 hours. She began dilating but had no feelings of contractions. She dilated to 1 cm. The next day she was given more pitocin, dilated to 2 cm, but still she felt no sense of contractions. At this point the nurse broke her water and inserted an internal fetal monitor. The fetal heart rate was falling and there was meconium in the amniotic fluid. She felt three “very painful contractions.” Because of the meconium and the signs of fetal distress the doctor ordered a Cesarean delivery. The subject had the option of being awake or totally anesthetized. She chose to be anesthetized.

The baby was born in severe fetal distress. Meconium was released and entered the baby's lungs and her blood vessels became very constricted causing a cardiac arrest. The baby was rushed to another hospital which had a Neonatal Intensive Care Unit. The mother saw her new daughter the fifth day, but was not able to hold her. The following day the baby had a cardiac arrest. The next morning she died. The mother held her baby for the first time after the baby had died.

The main theme of this woman's belief system was that she would never have children. This would also entail not experiencing pregnancy, labour or delivery. The subject did not ever touch, hold or nurse her daughter when she was alive. The baby's existence was never validated just as the subject's mother had never validated her existence (Wulfert 1986).

My next example is taken from research on observations of prenatal life with ultrasound as reported by Dr. Alessandra Piontelli (1987) from Italy.

Mrs. B. a woman in her mid-thirties, was very anxious when she came for the first observation. This was her third pregnancy and the second one had ended in stillbirth due to abruptio placentae. She was accompanied by her husband and all her attention was directed towards the placenta, its insertion, its shape, etc. and she kept repeating the same questions about it throughout the observation. Her husband, a man also in his mid-thirties, sat by her side and, though rather silently, appeared to foster her fears. No reassurance seemed enough to placate her obsessive questioning and her anxiety that something could happen at any time. The anxiety and the endless repetitive questioning remained constant features throughout the pregnancy.

On the second observation Mrs. B. came accompanied by her 7-year-old daughter and both now seemed obsessed also by another question: sex. Though one could already tell rather clearly that it was a boy, the question was repeated over and over again: What was its sex? Was it a boy or a girl? Was that the penis?, etc. Very little attention and space was given otherwise to the child.

During ultrasound observation, Gianni, the name given to the baby later, remained immobile, crouched in a corner of the womb, with his hands and his arms so tightly folded and crossed as to almost cover his face. His immobility, seemed born out of tension, if not terror. With his arms raised above his head sheltering his eyes and face, he looked very much like a figure out of a painting by Munch.

When the term approached he had not yet turned and was still tightly crouched in a corner of the womb in the transverse position. Since the child gave no sign of wanting to turn and Mrs. B.'s blood pressure continued to rise, a Cesarean section was decided upon. The obstetrician later told me that the child was so crumpled in a corner of the womb that she had considerable difficulty pulling him out. She said, "He would never have been born." Once she pulled him out the obstetrician was also struck by his immobility and by his fixed and sad look. "He looked old . . . 100 years old . . . it was somehow frightening to see the immobility of his face . . ."

During the next two months Gianni continued to be practically immobile. Whenever I saw him, his arms were kept at his sides, his head was bent backwards, his eyes were closed and he seemed immersed in a deep sleep. When his mother put him at her breast, he sucked slowly, frowning, with his eyes tightly closed and his arms at his sides, but he also clung to the breast for hours on end.

When Gianni was 6 months old his mother decided to go back to work. After that she said, "I feel as if I am breathing again . . . he seems better too . . ." and funnily enough, while she was saying this, Gianni let out two heavy sighs which sounded like relief. Though his gaze continued to be rather fixed and vacant, Gianni sometimes looked at me and smiled. He also accompanied his mother's endless inquiries about gynecology and sex with long constant sounds which reminded me in their tone of the endless talking of his mother. His

main contact with his mother was still the breast and Mrs. B. continued breast-feeding him until he was ten months old.

At the age of one year Gianni looked rather backward in his development. Though he could certainly sit and apparently crawl, he preferred to sit in a corner always holding the same toy and almost never moving about. So far I have heard from him only sounds and no words.

I think this case study clearly shows how the unborn child is assailed by his mother's anxiety and how from the beginning he tries to escape from it by moving into the furthest reaches of her womb. Of course, there is no escaping her obsessive ruminations, he is a helpless victim. He is not cared for lovingly either before or after birth. His chances of developing into a normal adult are slim.

The Effect of Positive Prenatal Communication on the Unborn Child

There is a growing literature on affectionate communication both verbally and non-verbally with the unborn child and its long term beneficial effects on post-natal bonding and personality. Renee Van deCarr (Van deCarr and Lehrer 1992), Donald Shetler (1989), Thomas Verny (Verny and Weintraub 1991) and William Sallenbach (1994) are just few of the many scientists who have studied the impact of a systematic program of prenatal communication between parents and their unborn, usually along a multiplicity of modalities such as speech, touch, music and others.

In many studies of psychotherapy in which regression is tolerated or encouraged we find verbatim reports of good and bad womb experiences. Perhaps because most of the subjects are psychotherapy clients, the recovered memories are predominantly negative. However, there are still plenty of happy, blissful moments that are re-experienced vividly especially in LSD Therapy as described by Grof (1976), Kafkalides (Janus 1991) and in the recent work of Piontelli with which I would like to close my presentation.

Mrs. D., a woman in her late twenties, was expecting twins. In her first ultrasonographic session her little boy (Luke) seemed much more active than her daughter (Alicia). Luke kept turning and kicking and changing position and stretching his legs against the uterine wall. As his mother remarked, "Oh my God! . . . look at him . . . he is so small and he is already fed up with being in there . . ." He conveyed the same impression to me. From time to time he would interrupt his motor activities and turn his attention towards his sister. He reached out with his hands and through the dividing membrane he touched her face gently, and when she responded by turning her face towards him, he engaged with her for a while in a gentle, stroking, cheek-to-cheek motion. From then on they were nicknamed by us 'the kind twins.' His sister, Alicia, initiated contact less frequently than he. Most of the time she seemed asleep, or else moved her head and her hands slowly almost imperceptibly, but each time responded to her brother's gentle stimulation.

Mr. D. was also present from the second observation. Rather shy and reserved, he was very gentle and loving.

After her delivery I went to visit her in hospital. Mrs. D. was very pleased to see me and told me about the delivery saying, "He came out first . . . then she came out too . . . their difference of weight is very noticeable . . . he is all skinny and bony and looks like a small bird . . . and their character, you know . . . just like we had seen inside . . . he is very

lively and alert . . . you remember how he used to move and play all the time . . . she is completely different . . . she is very calm . . .”

At one year of age they could walk and were beginning to talk and took a great delight in playing with each other. Their favorite game had become hiding behind a curtain and using it a bit like a dividing membrane. Luke would put forward his hand through the curtain and Alicia would reach out with her head and their mutual stroking began, accompanied by gurgles and smiles.

This case, though very much condensed from the original, clearly demonstrates the effects of positive parenting and a good mother-father relationship on the unborn child. Furthermore, it shows persuasively that prenatals are not, as commonly believed, in a so-called state of primary narcissism or, that they are autistic i.e. non-interactive socially. The twins in Piontelli's study are very much interested in reaching out to each other. In fact, there is a stunning contrast between poor Gianni hiding in isolation in a corner of his mother's womb and continuing to be reclusive after birth and the “kind twins” playing with each other prior to and after birth.

Summary

Every unborn child is bombarded in the womb by toxins that may be physical, chemical, hormonal or psychological in nature. At the same time, the unborn child is also the recipient of positive, nurturing and loving communications from its immediate environment, the mother and the larger world outside the mother such as father and siblings. The organic and emotional development of every child will be determined in a large measure by the balance between these opposing forces. This paper attempted to examine maternal and paternal messages that were largely of a negative nature. The effect of positive prenatal parenting was briefly examined. Looking at this material we are reminded of the over-riding importance of conscious parenting.

Conscious parenting, in its most ideal sense, involves the following three principles:

1. Personal growth work by each future parent to process any psychological complexes that may interfere with their becoming loving and caring parents.
2. An examination by each partner of their relationship to each other and a willingness to engage in open and honest communication.
3. An appreciation of the essential humanity of the unborn child and his or her need for love and affection both pre and post-natally.

The future of mankind may well depend on how successful we are at conveying to the world this simple but powerful message: As you do unto your own unborn children so will they do unto the world. Or, to put it in less biblical and more modern terms, there can be no world ecology without womb ecology.

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