The Development of Fears, Phobias, and Restrictive Patterns of Adaptation Following Attempted Abortions*

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Abstract: None available.

Full Text: INTRODUCTION If one looks at hospital and medical statistics, one usually finds figures for the number of terminations of pregnancies that took place either by birth, miscarriage, therapeutic abortion, etc., and estimates of illegal abortions. The possibility of attempted but unsuccessful abortion is not expressed in those figures. However, obstetricians are familiar with cases where a woman having had an abortion, attended to with hospital treatment and evacuation of the uterine cavity, returns a few weeks later apparently still carrying a persisting, uninterrupted pregnancy to term. This implies the likely existence of a partition in the womb. The incidence of this partition, called uterine septum, is reported to be 1 in 500. The incidence of an externally visible womb partition is said to be 1 in 10,000. The physicians are also familiar with ultrasound pictures which show existence of a fertilized egg in the womb that later disappears-the socalled blighted ovum. In such instances the remaining fetus will have been in close proximity to the events leading to the loss of a sibling fetus. It is surprising that we did not entertain suspicions before and investigated the possibility of emotional effects on the surviving offspring in such circumstances. This paper will be a summary of traumatic experiences related to me by 48 survivors of abortion attempts. The information to be presented came from patients under hypnosis. They suffered mainly from neurotic disorders, some had schizophrenic or manic depressive illness. They were showing good progress but had residual difficulties not amenable to therapy. Perhaps at this point it would be useful to mention how I came to realize the significance of what my patients were telling me. They provided the clues to a hitherto unsuspected association between abortion attempts and the acquisition of fears, phobic states, and maladaptive behavior. Years ago, during hypnoanalytical investigations of nightmares, panics, compulsions, etc., I often encountered detailed descriptions of underwater coral reefs, mobile walls moving in and out, of being stuck in dark chambers and similar descriptions usually connected with fear and often panic. I often wondered where these imprints came from. Repeating the investigation at intervals several times would bring the same descriptions, usually with additional data added until the complete experience was related. It finally struck me that the only mobile, rythmically contracting and enclosing walls I was familiar with as a physician were those of the womb. One day, while getting a detailed description of how the fearful person felt all curled up in a soft, dark corner trying to feel safe, I asked if she was aware of her body proportions. With that question being answered in the affirmative, I asked what was the size of the head in relation to the shoulders. When the answer was that the head was much bigger than the shoulders it dawned on me that I must be listening to a prenatal recall. I then questioned how many months the person had been in that residence. I was told three months. Later checking my embryology text, which, I must admit, I was no longer too familiar with, I discovered the given head-shoulder was accurate for the length of pregnancy; this was a fact I was not familiar with any longer when I elicited the response from the patient. Since then, I have used these body proportions as given by the patient as a guideline to the period of life the recall seemed to cover. My scientific difficulty to think in prenatal terms was also shown up by the same patient. Describing how she felt her body functioning after an unsuccessful abortion attempt, I asked her how the breathing was, forgetting for the moment that I was inquiring about a prenatal state and I got the answer in the typically changed voice of early life recalls, "I am not breathing yet." That taught me. A similar experience came, when I learned about ultrasound printouts and the so-called blighted ovum, which showed the existence of early siblings. I used to indicate to patients that their recall of early siblings could not possibly be true in the light of our present medical knowledge. It was as usual.

We learn most from the patients. METHODS To induce trance I use standard techniques. Some of the patients, all in intensive psychoanalytical therapy were also familiar with autogenic training and related methods of sensory awareness. This body awareness approach has the additional advantage of enabling the person to tap the data stream of proprioceptive sensations and body feelings. It makes him more aware of his body systems and their free or blocked functioning. Recall of the physiological response seems to synthesize with the emotions and judgement felt simultaneously. Then the investigation proceeds with Cheeks Ideomotor techniques coupled with Helen Watkin's approach to body departments and the information yielded by body feelings. The objective was to determine if the problem originated as a response to fear and, if so, under what circumstances. To reduce resistence during the course of therapy I instructed the patients to ask their mind nightly for dreams to throw light on their problem and to listen regularly to a tape of Dr. Greggs psychoanalytical suggestion. RESULTS Given the above what results did I find? I found that there are certain key signs that indicate early trauma and should raise the possibility of prenatal interference in one's mind. They range from recurring dreams and nightmares about disasters like water catastrophes, tidal waves, whirlpools, and tornadoes to earthquakes, ship disasters, etc., to irrational fears of being seen at night through windows or open doors, and food idiosyncrasies. The patients have the selfperception of being very tiny while the opponent seems to be 100 times bigger. With experience I realized that certain essential questions had to be asked of patients in order to elicit crucial information about all the circumstances surrounding their trauma, especially concerning the possible presence of siblings in the residence. The recall indicates awareness of all the environmental circumstances, for instance: availability of food and energy, often described as coming from a tube in the wall; existence of siblings and their location in the residence; as well as the mood, size, and attitude of people; and a sense for the passage of time. There seems to be awareness of physical changes like injuries, bleeding, restrictions, and changes of the quality and quantity of energy and fuel. This includes interference with their environment, details of the interfering agents, the direction of approach (usually from below) and the mastermind behind the threat. This results in fear of perishing and brings about the body coping mechanisms. The initial prenatal intervention is at first met with disbelief, then survival behavior starts and the person goes into a hiding and hold position, usually with the back braced against the wall and with appropriate adaptation of all body systems, especially reduction of food consumption and mobility. The experience of survival leads to precautionary measures when attempts at elimination appear about to be repeated and to an assessment of the chances of survival with respect to age, size, and nature of opponent. It seems that physicians are most feared in this respect. Survivors of multiple attempts show veteran-like attitudes, and feel that after the second trimester their increasing size will give them a better chance for survival. During the recall the physiological responses are appropriate to the memory. The patients don't seem to have any awareness or appreciation of the implication of the reported incidences to their present circumstances. This seems to come only after the patients are back into a near-normal or normal state of consciousness and even then comes often not at all or with great difficulty. They often stutter or whisper when particularly traumatic material is emerging or they come straight out of the trance. The reporting seems to come from two sets: * One as an observer looking on from somewhere usually a higher vantage point-The statements are then preceeded by "I see myself." * The other report is as the person in the experience. The interference with the prenatal habitat leads to fear of death. This centers mainly on possible injury, the ability to hang on to the uterine wall and the availability of food. In the womb the basics are reversed to shelter first, food second. The psychological effects of repeated interference with prenatal security are two-fold-irrational fears and maladaptation. The original fears are triggered again by seemingly similar situations in varying intensity. One could term it posttraumatic neurosis. Such responses include fear of invasive materials used in abortions or of dying during sleep. They include compulsive checking and rechecking rituals. The ability to hang on is threatened by motion of uterine fluid and walls. This is expressed in fear of water and motion. Fears centering around loss of shelter interferes with normal patterns of mobility and travel. Food-fears and phobias are plentiful, usually concerning supply or spoilage. A partial body

awareness of the fears is seen in hypochondriacal preoccupations and paranoid feelings The main pattern of adaptation to uterine invasion develops from the small size and basically stationary rooted position of the fetus in the womb, which excludes fight or flight responses. He reports that there is nothing to be done but stay calm and sit it out while preserving energy and believing it may go away eventually. Repetitive invasions lead to habit patterns of: nonactive behavior, procrastination, and hope that time will change things. The normal behavior pattern is one of undue compliance, reduction in assertion and self-defence. There is marked distrust of people that interfere with interpersonal relations. The term of "learned helplessness" could well be applied The loss of siblings needs special mentioning. Having been the survivor in abortion attempts leaves the person with mixed feelings. Although there is satisfaction about an end to competition for food there are strong guilt feelings for having survived; but the sadness and grief expressed is the most intense I have ever seen and is hard to take. People who have lost a sibling seem to have a permanent feeling of having lost a soulmate or twin and that nobody will ever be that close again or that somewhere in this world is an understanding person. They are quite definite on the sex of that somebody. The intensity of the maladaptation patterns appears to be increased with the number of conditioning experiences. However, it seems also to vary with the genetic and personality make-up of the person and their individual approach to handling difficulties. INFERENCES DRAWN There seems to be a definite effect of apparent prenatal learning on postnatal development. It appears that abortion attempts have to be considered the primary origin of some psychological difficulties which appeared resistant to therapy. The demonstrations of a correlation between the present anxiety or behavior pattern and its origin does remove the fears and phobias over a certain number of weeks. Change of behavior patterns require not only removal of the old but also the learning of a new pattern and that takes longer. However, it is important to recognize that, unless the original conditioning experience is dealt with, the fear or phobia will not disappear entirely. They may be diminished if therapy is directed to experiences which aggravated or reinforced the original conditioning, but the fundamental problem remains. The management of survival reportedly practiced by patients during abortion attempts appears to have similarities with the responses practiced by animals. This response in animals is termed "nonspeciesspecific immobilization response" and was reported on by the animal hypnosis section of this esteemed society at the Montreal meeting in 1974. I am simply reporting now a few of the more interesting examples of some 48 cases who exhibited manifestations which pointed to attempted abortions. Let me briefly describe a case to demonstrate spontaneous emergence of data. A 54-year-old independent business woman with children and grandchildren, recovering from depression, had spells of sleepiness and lethargy at times when she needed energy the most. Doing sensory awareness exercise for the first time, lying on the office floor, she experienced feeling increasingly younger and reported it. I said, "if you feel comfortable, stay with it." When she reported she felt in proportion more like a prebirth size, I repeated, "if you feel comfortable, stay with it;" she proceeded and, suddenly panicky, sat up. Finally, calming down, she said, "I wonder, if my mother tried to abort me, she had to get married at age 15 when I was on the way." A few weeks later she questioned her mother, who answered "I wouldn't do a thing like that," but the mother asked her daughter to go along for a walk in the fields, and asked how did she know? They discussed it and made peace. The next case is a 53-year-old professional woman, intellectually brilliant, who used to live with her domineering mother. Being an alcoholic she also suffered from chronic anxiety and cardiac arythmia. She underwent orthodox psychoanalysis. Following the death of her analyst I treated her for two years in the late 1960s. Following the death of her mother, she joined AA and returned in 1974 to learn methods to control her anxiety. Practicing self-hypnosis regularly, she felt she was coming closer to the origin of her fear state, and had dreams of her mother sending her messages which she could not read; she requested my help. Using the affect bridge resulted in recall of two abortion attempts. When seen again, she felt her anxiety had ended and stated that for the first time in her life, she felt free of fear. The verification of attempted abortions on the part of the mother was transmitted to me by the family doctor. The patient never did know about the prenatal intervention and I only found out very recently. The next case is a 27-year-old M.A. in Art and Archeology. She practiced TM for some time and was disturbed

by the spontaneous emergence of early childhood material which interfered with her work. She could enter into age regression voluntarily but found a black wall would block her whenever she approached a key event. Following a period of stabilization and sensory enrichment, repeated age regression under medical guidance finally eliminated the black wall. Recalls of multiple abortion attempts emerged and the patient settled. The mother was strongly opposed to the patient's seeking therapy and their visiting stopped. Several months after the important recalls, the mother initiated a visit. She asked her daughter how she felt about abortions and if she knew why she had attempted abortion, the daughter answered in the affirmative. Both in tears, the two women comforted each other and made peace. SUMMARY We recognize that the data are not absolute proof. However in view of the fact that the emerging material was not suggested, was unexpected both by me and the patient and verified later by reports from the mother, it seems very unlikely that this attempted abortion material is only a product of imagination and fantasy. Footnote * Paper presented at the annual meeting of the Society for Clinical and Experimental Hypnosis, Los Angeles, October 16, 1977. AuthorAffiliation Josefine E. van Husen, M.D.

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