# Love, Pregnancy, Conflict, and Solution On the Way to an Understanding of Conflicted Pregnancy

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Abstract: This article undertakes the momentous task of addressing conflicted pregnancy which is one of the most difficult tasks for a prenatal psychologist. We know and feel the importance of earliest life in the womb. We know how trust is developed prenatally and becomes the foundation for future relationships and how basic imprints are developed that impact the individual's future.

Keywords: conflicted pregnancy, abortion, conception, implantation, discovery

Early prenatal life may be threatened. The beginning consists of three key periods in every person's life. I propose to call this period of time, "The Early Triad: Conception, Implantation, and Discovery." Each of these will remain as basic patterns in the unconscious of the individuals. Conception will form and influence sexual attraction and desire. Implantation will lead to resonances in the fields of trust, supply, feeling safe, and being in good hands (Linder, 2014). Discovery refers to the moment when the woman consciously realizes that she is pregnant, which later reflects as conscious recognition of and relating to others. The period of life when these three developmental steps are happening is actually quite short, consisting of about three weeks. Conception takes place at about the 14th day of the mother's menstrual cycle, implantation occurs three to five days later, and discovery usually within the 1st week after missing a menstrual cycle.

Discovery can be understood as conscious perception by the mother. However, besides that recognition, there are many layers of body functions, body sensations, and subtle changes of mood going on within her. Everything is adapting to the new goal. Biology is going on her way, not necessarily asking for consciousness or gray matter brain function.

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It can be a time of questioning for the mother—will she be able to have this child? This is a common situation in a gynecological office. Many women are happy to become pregnant. But some are not. There is a wide range of reactions, from some discomfort to total devastation and alienation. This may look like a total lack of empathy.

In 2005, my colleagues and I began this discussion of conflicted pregnancy and were compelled to find a way to deal with it. In that year the Charter of the Rights of the Child Before, During, and After Birth was formulated and approved (see appendix). That document was based on the 1989 UN Convention on the Rights of the child. The purpose was to extend rights to the time before birth and also to focus on relationship-oriented and low-intervention birth and deep support for bonding processes after birth.

During the membership assembly of the International Society for Prenatal and Perinatal Psychology and Medicine (ISPPM) there was wide and vigorous discussion. Deep and strong objections were made, concerned that these new rights could be used to criminalize women or doctors, who asked for, or performed abortions. So it was decided an addition was needed: ***"Clearly these rights are subject to the relative rights of others, particularly of the mother and family. Those with responsibility need to balance these relative rights with understanding of the issues involved, including those of the child."***

At this same membership assembly I had the honor to be elected as president of ISPPM. It appeared obvious that facing the essential and fundamental contradictions regarding the rights of women and the rights of the unborn was essential. It was time to organize a meeting focusing just on these questions. This meeting occurred in 2006.

International Society for
Prenatal and Perinatal Psychology and Medicine (ISPPM)

*19th Workshop in Heidelberg*
*Nov 17th – 19th, 2006*

**Love, Pregnancy, Conflict and Solution**

– Discovering the Psychodynamics of Pregnancy Conflict.

Delving into this delicate topic, it is necessary to acknowledge that many different attitudes can occur in life and show up in a gynecological office. This topic touches upon all aspects of psychosexual development, personal past histories, the current situation as a couple, social ties, one's own early experiences, self-image, and trans-generational factors that are the significant forces. You will find a range of personal aspects more extensively described in my article (also in this issue), "Conflict of Pregnancy-Experiences from a Gynecological and Psychotherapeutic Practice."

However: it is helpful to keep the following numbers in mind:

> of 1,000 pregnancies, only 400 implant successfully,
> of the 400, about 10% (40) end in miscarriage,
> of the remaining 360, 15% (54) of the embryos die as a result of abortion
> 306 are born alive.

Every year in Germany around 100,000 fetuses are aborted, compared to more than 700,000 births.

Here you can see the development within the last 15 years in Germany (from the Federal Statistical Office of Germany):

**Induced abortions in Germany**

| Year | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Live Births | 766,999 | 734,475 | 719,250 | 706,721 | 705,622 | 685,795 | 672,724 | 684,862 | 682,514 | 665,126 | 677,945 | 662,685 | 673,544 | 682,069 | 714,927 |
| All induced abortions | 134,609 | 134,964 | 130,387 | 128,030 | 129,650 | 124,023 | 119,710 | 116,871 | 114,484 | 110,694 | 110,431 | 108,867 | 106,815 | 102,802 | 99,715 |
| Abortions per 100 live births | 17.55 | 18.38 | 18.13 | 18.12 | 18.37 | 18.08 | 17.79 | 17.06 | 16.77 | 16.64 | 16.28 | 16.43 | 15.86 | 15.07 | 13.95 |
| Abortions per 100 live and stillbirths | 17.48 | 18.3 | 18.06 | 18.05 | 18.3 | 18.02 | 17.73 | 17.01 | 16.71 | 16.58 | 16.23 | 16.37 | 15.8 | 15.02 | 13.9 |
| Abortions per 1000 women aged 15 - 45 | 8 | 8 | 7.8 | 7.6 | 7.8 | 7.5 | 7.3 | 7.3 | 7.2 | 7.1 | 7.1 | | | | |
| Abortions per 1000 women | | | | | | | | 6 | 5.8 | 5.8 | 5.9 | 5.9 | 5.9 | 5.7 | 5.5 |

**Outpatient and inpatient pregnancy terminations, pregnancy terminations per 100,000 women and per 1,000 live births. Classification: years, region (place of residence), age**

Shown values refer to:
**Region:** Germany, **Sachverhalt:** Pregnancy terminations per 100,000 women

| Age | Year (descending) | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 |
| All age-groups from 10 to under 55 years | 537 | 538 | 542 | 537 | 551 | 549 | 529 | 519 | 527 | 507 | 492 | 483 | 476 | 464 | 465 | 468 | 461 | 446 | 433 | 433 |

A gradual decrease of the number of abortions can be seen, in relation to the live births and as well a decrease in relation to the total number of women between 10 and 55. Possible reasons of the decline might be: good access for women of any age to contraception, a functioning system of counseling for pregnant women which is open-minded and accepting of the

woman's decision, and possibly a growing public attitude to accept the value of prenatal life.

## What about the History of the Abortion Issue?

In this issue of JOPPPAH, Dr. Ludwig Janus addresses the history of abortion. Dr. Janus shows that there is a link between a patriarchal structure of society and the women's ability to make decisions about her life and her generative issues. Rights of the unborn hardly existed in early times and gradually evolved with social developments of legal structures and women's rights. Deep changes of people's consciousness and time-dependent agreements have been ongoing. However, over time, humanizing of conditions can be recognized and gradual acceptance into social understanding observed.

Sven Hildebrandt (2008) described severe ambivalence one step earlier: dealing with contraceptive devices. Reliable contraception is possible today. Why do some women not accept or effectively use family planning? And later not feel able to have the baby? This leads us to believe that the ambivalence must be positioned much deeper in personal history and structure. (See the example of Mrs. C in my article, Conflict of Pregnancy-Experiences from a Gynecological and Psychotherapeutic Practice, included in this issue of JOPPPAH).

Justine Buechler (2008) endeavored to describe the different life situations of women in pregnancy conflict:

1. Pregnancy does not fit into her life plan
2. Pregnancy does not fit into an involved person's life plan
3. Pregnancy has arisen from a secret love affair
4. Pregnancy has arisen while separating from the partner
5. Pregnancy occurred when she has finished family planning
6. Pregnancy created total cleavage/conflict about whether to have the child or not
7. Pregnancy was originally accepted, but then severe disability was discovered
8. Discovery of a life-threatening disease of the baby or mother was discovered.

In contrast with post-traumatic stress disorder, where a severe extrinsic derangement brings one out of balance, in these situations more silent embitterment is going on, resulting from severe conflicts that violate inner moral attitudes or basic assumptions.

It is evident (see example below) that early influences have deep effects on the patterns of intimate relations. Subtle therapeutic work with couples is done by Franz Renggli from Basel. He and his colleague, Carmen Ehinger (2008), have reported how they began to realize more and more the impact of unresolved early prenatal and birth trauma on conflicts in partnership. The earlier and the more unconscious these are, the more deeply they influence our behavior towards our partners.

> We observed that many of our clients had chosen partners whose early life traumas were often the exact opposite of their own. For example, a person who was the long awaited and overprotected child after a miscarriage might choose a partner who was a survivor of attempted abortion. These complementary traumas seem to fit like a key into a keyhole and are on one side causes for mutual attraction and on the other hand, carries of immense conflict potential. While working with couples, we began to consider their conflicts in the light of each partner's prenatal traumas especially their earliest existence.
>
> Whenever we could successfully trace back an actual pressing conflict to the clients' mutual prenatal wounds, the couple was often able to find a way back to respectful and loving understanding of each other. On the basis of these experiences we assume that emotional outbursts and tensions in a partnership need to be traced back into early prenatal times. The partner may become the trigger for current conflict. The way out is to teach couples strategies how they can see and deal with their mutual prenatal wounds (p. 162).

To further illustrate these conflicts, Renggli and Ehinger choose this poem of Erich Fried, a master describing the dark side of love:

| **To a nerve-killing saw** | **An eine Nervensäge** |
|---|---|
| With your problems,<br>they say,<br>you are<br>like a nerve-killing saw<br><br>I love the sharp end<br>and cutting edge<br>of every single<br>tooth of this saw<br>and its shining blade<br>and its round handle, too | Mit deinem Problemen<br>heißt es<br>bist du<br>eine Nervensäge<br><br>Ich liebe die Spitze<br>und Schneide<br>von jedem Zahn<br>dieser Säge<br>und ihr blankes Sägeblatt<br>und auch ihren runden Griff |
| From German: Renate Meyer | Erich Fried |

Many of the shadow side aspects of love can be found in the example Mrs. O below, as well in the article, On the Psychodynamics of Preeclampsia and HELLP Syndrome (Linder, 2014).

## The Prenatal Child and Society

In 2007, another key moment in this field occurred in Moscow. It was a session during the Joint Congress of ISPPM and the Russian Association for Pre- and Perinatal Development (RAPPD) with the title, "The Prenatal Child and Society: The Role of Prenatal Psychology in Obstetrics, Neonatology, Psychology, and Sociology." Because of some difficulties we were employing consecutive translation. In a smaller auditory group, people were listening to a lecture by Klaus Evertz titled Psychodynamic Aspects of Problematic Pregnancies Expressed in Images (see the related article in this issue). The auditory session was crowded, so people needed to sit closer together. Because of the slower pace of translation (English and Russian passages following each other), the reaction of all participants could become much more obvious. The pictures—as you can see in Evertz' article—show very clearly the emotional feeling of men having undergone the threat of abortion attempts. Elena Tonetti, who is well-acquainted with the Russian society, gave a remark on Russian contraceptive behavior, "we know that a woman in Russia with age 45 has had an average of 7.5 abortions in her life? And it can be up to 22." A continuing and affected murmur was going through the hall. It brought up the serious question that continues to echo: What effects does this way of family planning have on the inner (and outer) peace of a society and on the estimated value of human life in general?

What influence can it have on the people and society that has experienced so many losses of children, siblings, cousins, uncles, and aunts?

To illustrate this I want to share an example with you.

## Case Study: Mrs. O

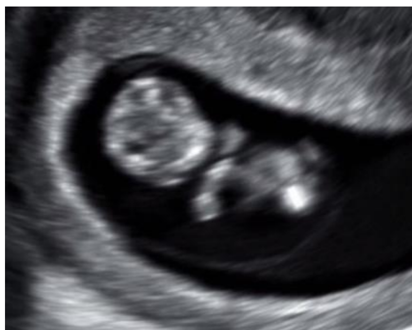
Mrs. O, when she first came into my care, was a 31-year-old woman, just recently pregnant (in the 6th week). At the age of four years she had moved with her parents to Germany from an East European country. Two years ago she had breast amplification. She is a dynamic, well-groomed, and superficially extroverted person. She stated, "For seven years I have had a strong wish to become pregnant. Now I have pains and aches everywhere. I could reduce my smoke habits from 20 to 12 every day."

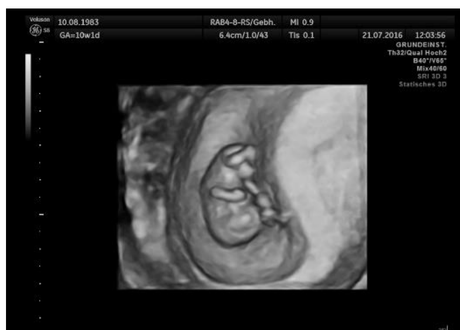
She has been living together with her boyfriend for one year. Physical findings were positive. A little later, she reported that her eating habits ranged between nausea and eating attacks and said, "All my friends are having either extrauterine [ectopic] pregnancies or spontaneous abortions..." In the 12th week she had a little bleeding, the fetus was much too small without any heartbeat visible by ultrasound. Curettage was performed a few days later.

After that she felt very bad. She was hardly able to sleep and to handle daily needs. In addition to psychotherapy, a little dose of Amitriptyline was necessary for some weeks. She was questioning her relationship with her boyfriend, even though a marriage had been planned. She said, "Whatever he is doing, it bothers me." She was eating badly, smoking, and drinking a lot of coffee. All people in her environment were saying, "Don't worry; you will get the next baby soon."

She remembered that her mother had had some abortions. A twin of her brother had been miscarried. Her boyfriend already has a son, who was not wanted. He has little contact with his son. After a month of treatment, she said, "I am pulling myself together. Things go better. I have better feelings to my boyfriend than ever."

Five months later she was pregnant again. Her emotions were like riding a rollercoaster. She had nausea and withdrawal from nicotine, having stopped smoking from 30 cigarettes to zero just two days before. Three days later she reported that she is haunted by nightmares, but she has things "well in hand." She also quit coffee and cola drinks. I gave her frequent appointments. At the next appointment, she reported that once she had not slept and everything has become blurred. In a dream she saw a corridor in an operation theatre, including chopped limbs. She reported, "My mother has had quite a few abortions: There were only three children from 10 pregnancies. Most were after me." She remembered waiting in a car while mother went for an abortion to be done. Mother did it because father was treating her badly. At this appointment a gestational sac was visible, the heart action not yet. Two weeks later a friend lost her child in month five of her pregnancy. However, there was heart action visible at this appointment. I am offering weekly controls in endangered pregnancies, since it is dramatically enhancing their chances. Often Mrs. O is coming in panic before the checks, but shows considerable relief after them. This time there was the chance to show her the teddy bear appearance around the 9th or 10th week.






Teddy bear appearance of fetus around the 9th or 10th week.

Mrs. O wanted an ultrasound every check, until she could feel the motions of her baby. Before the check she had a kind of exam anxiety. Once she had dreams of a premature birth. The baby needed to be in a glass box with bandages on it. In the 27th week the cervix was dramatically shortened to 25 mm and the head of the baby pressing on it. She was prescribed medication (Progesterone, Tokolytikum oil, Magnesium, and Bryophyllum), but vigorously refused an Arabin Cerclage Pessary. Her mother has had a pessary with her sister's pregnancy and experienced a seven month premature birth just three days after having one inserted. Mrs. O had her marriage at the weekend. Labor pain every three minutes and the cervical os elapsed. Now she could agree to the insertion of an Arabin Cerclage Pessary. She also got my personal mobile number for emergency calling. After a few days adapting to it the pain relieved and things significantly calmed down. In the 36th week the pessary could be removed. For a while she was considering a caesarean and had even made an appointment with the hospital for the procedure. Finally she could agree to labor's induction one day after the estimated date of delivery. A daughter at 2820 grams (6.22 lbs.) and good Apgar scores was born. The baby was fine. Although she was crying more during the day and they were hospitalized once for two days because of threat of sudden infant death syndrome (SIDS).

Half a year later she came pregnant again. "It happened unexpectedly for me. I was shocked the first two days. But my husband is so happy." She did not feel very much being pregnant. Her mother was encouraging her to go for an abortion, saying, "it's not a baby yet." She also said, "Grandchildren are loved more than personal children." Again we talked a bit about the abortions that her mother has had. The legal regulation in Germany that compulsory counseling and a three-day waiting period to think things over is required was explained to her.

These considerations never came up again. She was losing some weight because of nausea. Regarding her husband: his father emigrated from Asia Minor, his mother was from southern Germany and was 17 when he was born. During his gestation, his mother had smoked and drunk alcohol. He was almost given to adoption, but his grandmother intervened, saying, "He shall stay." The husband already has a 12-year-old daughter, conceived from an earlier relationship. He has had little contact after a very destructive conflict with her mother. Once Mrs. O came for an intravenous infusion because of nausea. In a very impatient manner she suddenly left and could not wait any longer. But the visit relieved the morning sickness.

This pregnancy is still in process. She has described pain like twitches and lightning in her belly. Because of a cervical dilation with a funnel syndrome it was necessary to administer a Cerclage Pessary again, which she tolerated much better. It led to a dramatic recovery of the cervix. She was able to relax for a week's vacation together with her husband for his birthday.

This case demonstrates how serious attempts or abortions in the previous generation can influence the life of this woman. The serious complaints and acting out may indicate that she herself has been threatened, at least by abortion thoughts. She has lost many siblings, even waiting in the car during one of mother's abortions. She lost her first child by a spontaneous abortion, throwing her into severe grief. She still gets a recommendation to do an abortion by her mother during her 3rd child. Her husband also comes out of a confrontational relationship and himself is father to an unwanted child. The way she acts things out shows how much she is imprinted by this tension-filled way of relating. Her smoking habits show self-destructiveness in a repetitive matter. However, although she has refused to formally apply for psychotherapy, her slow but gradual relaxation is obvious. She repeatedly could share her early living conditions and her early threat—in a way that was tolerable to her. Inevitably it is necessary to share such insights to another person being empathetic and not falling into shock oneself. Only this can relieve the tension and give a chance to develop other and better choices of life.

## The Work of John Sonne

John C. Sonne, a pioneer of merit in studies of the consequences of abortion ideation, has diligently described severe prenatal trauma issues in his article, Interpreting the Dread of Being Aborted in Therapy (Sonne, 1996). He illustrates, "how the sequelae of prenatal trauma can be

transferentially expressed in a variety of pathological symptoms in postnatal life." Certain characteristics are pointed out:

> 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; they 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. … They often describe themselves as incurable, often on the basis that they consider themselves genetically flawed (p. 319).

However, for good reason Sonne emphasizes the knowledge of Kandel (1989) that genetic programming is reversible:

> Abortion survivors can only make limited use of poetic metaphors and metonyms in their speech, and have little sense of humor. … They have extreme difficulty trusting. They are not thankful, grateful or appreciative. There is a danger of suicidal thoughts or even committing suicide, potentially also homicide (p. 320).

The meaning of the messages communicated by the traumatized unborn are "known but unthought" by the patient until the associated links are interpreted in therapy. But: "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…" (p. 317).

> Once the therapist has become more open to the prenatal dread of his patients and at least partially convinced, he will begin to understand 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 (p. 319).

Another diligent article by Sonne (2002), On Tyrants as Abortion Survivors, describes the personal history of well-known historical figures as Adolph Hitler, Joseph Stalin, Saddam Hussein, and Osama bin Laden. In all of these he finds a background of abortion survivor-hood. And

another observation, which we can see also in present time: Tyrants often act out their tyranny in the name of religion.

The work of Sonne was an outstanding achievement within prenatal psychology. It has put a new perspective on serious aspects of early human life. Luckily, in more recent times, things can even be further differentiated. There are many fine-tuned gradations of mother's response or parent's reaction, during the discovery phase (Terry 2009, Linder 2014) listed here:

1. Unsuccessfully attempts at abortion
2. Goes for an abortion but has second thoughts at the last minute
3. Child unwanted, disaster, thinks about "doing something to get rid of it"
4. Child unwanted, disaster, thinks about abortion
5. Child unwanted, negative thoughts, "maybe it'll work"
6. Child unwanted, but accepted
7. Child wanted, but not now
8. Child wanted, but should be of a specific sex
9. Child wanted, but for a reason that has nothing to do with the child
10. Child fully welcomed to be itself, relaxed

So these are obviously different states of mind. Some of them can even be acting in parallel. And for the treatment it is important to know: one thing is the definite version having happened at the time of discovery. Were there differences between the parents? How did things develop over the next and further years? How openly could it be handled from the parents' and kids' side? One side is looking at it from a position of information and another from the emotional side. What possibility did the emotional aspects have to develop? What chances did the involved persons have to work on their relation? And how can we work in therapy to bring things forward?

## Conclusion

The deep influences of very early life experiences have been underestimated, especially life events during The Early Triade: Conception, Implantation, and Discovery. The imprints of this time can last for the rest of the life.

In case of unhappy events during this time, there is a tendency toward re-enactment of the dynamics in personal and intimate relationships,

especially when becoming pregnant (which certainly is another intimate relationship).

Since couples becoming pregnant inevitably get into touch with their own early feelings, it is necessary for all caregivers to keep these dynamics in mind in order to provide these couples with appropriate support.

For governing bodies it is important to find wise regulations, which honor both sides: the situation of the woman and the dignity of the unborn. Well-balanced legal procedures are necessary to guide all relevant parties: women, doctors, counseling agencies, and others. The agreement of wide segments of the population is helpful as it will exclude parts of the destructive psychodynamic energy originating from the key questions regarding abortion in the political discussions.

When counseling pregnant women and their partners it is vital to understand their underlying dynamics. Continuity of caregivers in these fields is definitely needed. It is crucial for the resolution of conflicting situations in this field. Here it cannot matter what the decision finally will be. However, this necessary tolerance is a hard issue for all the people involved. But this kind of support will enable people in conflict to move forward in their personal development and come to more balanced decisions.

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