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Prenatal and Perinatal Influences in Contemporary Jungian Analysis

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Abstract: This article begins with Jung's remarks on pre-birth influences and birth trauma and moves forward to integrate object-relations theory. With ample case material, the author takes us into her consulting room where she describes her clinical experiences of prenatal life, the birth process itself and the period just after birth. The article then distinguishes between behavioral memory and Freud's perceptual memory, making the point that birth trauma, a behavioral memory, is preverbal, intense and often re-enacted in the transference-countertransference configuration. Different alchemical stages of a Jungian transformation process are described, particularly *mortificatio*, *separatio*, and *coniunctio*, with examples of how a patient with birth and/or prenatal trauma may require special sensitivity on the analyst's part in order to navigate change. The author concludes that when exploring this area of psyche both analyst and patient may encounter intense pain and chaos but that this is compensated by the patient's relief that the analyst is willing to traverse this difficult territory.

Zusammenfassung: *Vorgeburtliche und geburtliche Einflüsse in der zeitgenössischen jungianischen Analyse.* Dieser Beitrag beginnt mit Jungs Bemerkungen über vorgeburtliche Einflüsse und das Geburtstrauma und geht dann weiter zur Integration der Objektbeziehungstheorie. Mit ausführlichen Fallbeispielen nimmt uns die Autorin in ihren Praxisraum und beschreibt ihre klinischen Erfahrungen mit dem pränatalen Erleben, dem Geburtsprozeß selbst und der Zeit nach der Geburt. Der Beitrag unterscheidet dann zwischen Handlungsgedächtnis und Freuds Wahrnehmungsgedächtnis und betont, daß das Geburtstrauma als Handlungserinnerung vorsprachlich und intensiv ist und oft auf der Übertragungs- Gegenübertragungsebene durchgespielt wird. Die verschiedenen alchemistischen Stufen des jungschen Transformationsprozesses werden beschrieben, insbesondere die *mortificatio*, *separatio* und die *conjunctio* anhand von Beispielen, wie ein Patient mit einem Trauma bei der Geburt und/oder vor der Geburt einer speziellen Sensibilität eines Analytikers bedarf, um zu einer Veränderung durchzudringen. Die Autorin schließt, daß bei der Erforschung dieser Bereiche der Seele Analytiker und Patient intensivem Schmerz und Chaos ausgesetzt sind, daß dies aber durch die Erleichterung des Patienten darüber ausgeglichen wird, daß der Analytiker ihn wirklich durch dieses schwierige Gebiet hindurch begleiten will.

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Therapy must support the regression and continue to do so until the prenatal stage is reached . . . The so-called Oedipus Complex with its famous incest tendency changes at this [prenatal] level into a Jonah-and-the-Whale Complex, which has a number of variants.

C.G. Jung

Speaking of birth trauma at the 1989 Jungian International Congress in Paris, I felt shy in presenting my hypothesis that what had caused me deep emotional pain in my certification interview was memory of my own traumatic birth. From my infant-psyche point of view, leaving the container of the training program stirred feelings about leaving the womb.

Drawing on the writing of D. W. Winnicott, I emphasized the physical and psychological experience of the birth process, and the period immediately after birth. Since 1989 I have begun also to look at the impact of prenatal experiences which, like the birth experience, can be observed in transference/countertransference phenomena. The works of W. R. Bion, Yvonne Hansen, Neil Maizels, Erna Osterweil, Michael Paul, Alessandra Piontelli, Otto Rank, Lynda Share and Frances Tustin have helped me to explore this area.

Although Jung made some disparaging remarks about the literal aspects of birth trauma – for example, calling it "a famous obvious truism" (CW2, §842) – he strongly emphasized pre-birth influences, most notably in relation to his concept of the collective unconscious. References in his works to destiny, fate and vocation also emphasize prenatal influence. One of the most interesting such references occurs in the 1935 Tavistock lectures (CW18, §205), mentioned in Bair's (1978) biography of Samuel Beckett.

Beckett's analysis with Bion had reached an impasse. As a farewell to the analysis, Bion is said to have taken Beckett out to dinner and to hear Jung at Tavistock. Beckett was taken with Jung's view of complexes, since his experience of creativity was about being seized by an autonomous force that demanded expiation. A casual comment by Jung affected Beckett deeply:

> In response to a question about the dreams of children, Jung mentioned a 10-year-old girl who had been brought to him with what he called amazing mythological dreams. Jung could not tell the father what the dreams signified because he sensed they contained an uncanny premonition of her early death. Indeed, she did die a year later. Jung said, "She had never been born entirely." (Bair 1978, p. 209)

It was the words, "She had never been born entirely" which, according to Bair, profoundly affected Beckett, who

> seized upon this remark as the keystone of his entire analysis . . . . He was able to furnish detailed examples of his own "womb fixation," arguing forcefully that all his behavior, from the simple inclination to stay in bed to his deep-seated need to pay frequent visits to his mother, were all aspects of an improper birth. (Bair 1978, p. 209)

No one's personality is so uncomplicated that any single trauma or memory explains everything. But the events around one's birth, or the days immediately following birth, leave a profound imprint and tend to be re-experienced at times of separation and transition. When they are not experienced consciously, they have a dark, pessimistic, agitating, stifling, debilitating, and sometimes terrifying impact.

These earliest memories often have both physical and psychological correlates and frequently carry a seeming life-and-death urgency, which Bion has described as "catastrophic anxiety." Patients experience intense pain – but a more intense sense of gratitude and relief – when these pre-verbal birth memories are made conscious in the analytic process. I feel that, as analysts, we have a responsibility to learn more in this area and to build on Jung's early intuitions.

Prenatal Life

Freud noted in 1926 that there was more continuity between prenatal and postnatal life than the dramatic caesura of birth would lead us to believe. In recent years we have impressive new data that confirms Freud's idea. Piontelli (1992) observed infants in utero and afterward. She found that temperamental differences can be observed in utero and continue to manifest in the life of the developing child. One dramatic example was an infant, Julia, who actively mouthed and licked the umbilical cord. As a young child she was sensuous and self-absorbed. Brought to treatment at age three, Julia always had pockets filled with food, once as many as eight pockets.

Paul (1988) has observed the prenatal experience, indirectly, in his Los Angeles consulting room. A woman patient dreamed "she was in an autopsy room watching the end of a postmortem, which then transformed into an embalming scene. She saw the circulatory hook-up clearly and, as the process was begun, she awakened screaming from her dream and could not shake off the hideous sensation of being flooded and engorged with fluid" (p. 555). At the time of this dream her choking phobia returned. She questioned her mother, who reported having toxemia, which was exacerbated during her pregnancy prior to the patient's birth.

In my own practice I have observed dramatic examples of prenatal trauma. "Beth" has been in analysis for many years. When she began treatment, she was suffering from anxiety and psychosomatic problems. She felt overwhelmed with responsibilities that left little time for herself. Her mother had cancer while pregnant with Beth and underwent radiation treatment during that time. Beth often felt that things were "coming at her," that the world was not safe. She had never had a safe place to be a baby or little child. These themes dominated the treatment.

Recently Beth and her husband moved into a new home. The previous home was smaller, cozier, near the ocean, and womb-like. The new home felt larger, lighter, more out in the world, part of a more established neighborhood. The session after the move, Beth lay on the couch sobbing, holding her head contracted in pain. She said, "I hate the new house and the new bedroom; there are no curtains and too many windows. The light is streaming in, and I feel bombarded and exposed. My husband likes the new windows with no curtains and the bright carpet. I'll never feel comfortable. I can't get comfortable." As she talked I felt her fear that I would not hear her or comprehend her terror. The verbal crescendo and despair were building, and I said quietly, "Do you think this might have to do with your experience in the womb with your mother's cancer and radiation treatment?" Her hands came down from her head as the agony began to subside. She cried then very quietly and we could begin to talk about the pain.

Sarah, another patient with prenatal trauma, comes four times a week. During the first years of treatment I had, two days a week, an office without windows. Although I preferred the office with windows, Sarah preferred the womb-like "dark one." As the analysis proceeded, it became clear that Sarah's depression intensified before her younger sister's birthday each year and before her own birthday, she would feel as though her body were filling up with dark fluid. She felt such pressure in her head that it seemed as though her whole body might explode. She would say that she couldn't get comfortable and was afraid of dying when away from me. She would also feel pain in her teeth. She might visit a chiropractor or an ENT doctor during this time, also without relief. In the somatic countertransference, I experienced her extreme feelings of lethargy and fatigue.

Sarah's mother suffered from high blood pressure and smoked excessively during her pregnancy with Sarah. When I offered the interpretation that the womb might have been toxic and that maybe she had indeed been in a life-or-death situation, Sarah's fear of dying began to diminish. She also felt that as a baby in utero and after birth she had gone "mindless" to blot out the pain. Although she felt grateful and relieved when an interpretation was made, it has taken several years for the physical symptoms to become identified cognitively. In the periods before her birthday, what seemed important for me was to stay alert and active, to ask her to report on what was happening in her body and mind. I experienced a strong countertransference pull toward fogginess, sleep and mindlessness. Over time I learned not to identify with her despair or her terror but to stay respectful of her feelings and help her verbalize her intense pain.

A third example is my patient "Robert," who knows from his mother's medical history that she suffered from hypertension during her pregnancy with him. This was a high-risk pregnancy, and Robert was delivered by caesarian section. In the period before his birthday he is always more depressed, lethargic, and tense, as if awaiting a catastrophe. After the birth date passes, the depression and anxiety lessen. During this time he often draws pictures that look like in-utero creatures that are developing but may be aborted. A recent dream was of "two very sad-looking in-utero babies, with Robert looking into their eyes and seeing sadness."

All the patients just described are extremely sensitive to stimuli from the environment and to receiving projections. All are hypersensitive to others' needs but resentful of being in this role. It is hard for these patients to focus on their own desires, for they feel guilty and fear punishment when something good is happening to them. They long for a secure protected womb in which to develop.

Rosenfeld (1987) discusses Felton's (1985) work on fetal osmotic pressure and quotes from her work with autistic children and their mothers. Felton hypothesized that dissociated contents in the mother's mind, which she found disturbing, were activated during pregnancy and seeped into the child's unconscious. Felton called the process "osmotic pressure." The fetus seems to be helpless to ward off such pressure. Children from such a prenatal environment may be phobic toward their mothers. "They are terrified that they may ... have to guard against something very frightening which is being forced into them" (Rosenfeld 1987, p. 277). They may feel also they have too little skin or boundary. The patients I have described in this section reflect many of these characteristics.

The Birth Process

Paul (1988) discusses the feeling of pressure as being central to the birth process. He notes that the word *pressure* derives both from Middle English and Old French, *pressen*, *presser*.

> Literal and directly connected senses of pressure include: to exert a steady force; to press to death; to execute; to compress; squeeze; extract. Figurative senses of pressure include: to bear heavily on; to reduce to straits; to beset or harass; to oppress; to crush; to distress or afflict; to weigh down; to burden (mind, feelings, spirit); to produce a strong mental or moral impression; to urge on, compel, force. (p. 564)

These images and feelings can help us understand the infant's experience of birth.

Movement from inside the mother's body to outside it may result in sudden overstimulation and painful feelings of being raw or cold. This movement is a dramatic moment often replayed in child play and possibly re-enacted in analysis. Leaving the consulting room may evoke such painful birth feelings. Several patients have told me how "out in the cold" they felt when my consulting room door closed. One of Paul's patients dreamed of feeling very small and unprotected after birth, like a shrimp without a shell. The patient had had a difficult birth, and Paul's countertransference experience was of this patient verbally beating against him. I have noted patients doing this before vacation breaks – asking repetitive questions in an extremely aggressive and invasive way – beating against me as if trying to get inside my body to avoid the pain of separation.

With Paul's patient it was possible to reconstruct that her mother had developed uterine inertia that resulted in caesarian section. During each of her menstrual periods this patient would beat verbally at Paul and call him at home. He surmised and interpreted that her menstrual periods were experienced as if she were giving birth to a damaged baby, which had been pounding against the uterine wall again and again, attempting to emerge. Paul points out that each birth is nothing less than a major stage in evolution, which required millennia in the history of phylogeny to occur. In a human birth, this transition from inside a watery environment to an outside gaseous one occurs in a matter of seconds.

From my own practice comes an example of how the image of birth comes up at the time of a potential life transition. "Judy's" birth was induced. She comes from a family in which there is a generational difficulty with separation. Judy's birth was difficult and her mother suffered from depression from the loss of a parent shortly after the birth. Judy is in a new relationship with the most suitable man since I have known her. This man is bright, in her profession, and available. He also likes her! In the past she has picked rather unavailable men. Several months prior to the session here described, a fourth session had been added with the idea that if she could experience more contact in the analysis, perhaps she could tolerate more intimacy outside the analysis.

Judy is partly excited by the new relationship but also terrified of the feeling, which she states is the horror of being more separate from me and from her parents. She tells me she is thinking of *Alice in Wonderland*: "This new relationship feels like falling into a rabbit hole." There is terror in her voice when she asks how could Alice tolerate her adventure? Things going from big to small, changing sizes, growing, shrinking, unfamiliar. She seems to intuit the feeling of havoc that

will be unleashed in her by this new relationship to me, as well as to the boyfriend if she can let the adventure continue. She says Alice has to meet all these strange people (parts of herself, her feelings). "It doesn't feel safe to me. I'm not Alice. I'd want to be home with Mom."

Near the end of the hour Judy told me a recurring dream from her childhood.

She was going down into the ground by wooden stairs. Maybe it's the underworld; there's no going back, and it's scary going forward as in the rabbit hole. There is scary stuff in the passage. You have to go through to get out.

In a subsequent session she begins by saying she noticed she was angry driving over to the session. She said that I had pushed her out at the end of the last session, after I had said it was time to stop. She kept talking, and I had said, "We really need to stop." This upset her, as she thought it was an especially good session and wanted to savor it. My comment made her feel that I just tolerated her and that my office was a factory. Near the end of the session, having talked about her ambivalence and resistance to her new boyfriend, she said, "I just want to be a cute kid, forgiven for everything and allowed to act young. Not a stiff, married, traditional adult." After a pause, she added, "I'm over 40, and I still want a perfect childhood."

I said she seemed to be longing for paradise, that maybe she was longing for the womb. Offered the new relationship and the feelings and anxieties it stirred up, parts of her wanted to go forward while a lot of her wanted to go back. Paradise. As a countertransference reaction, I now had images of her grandmother's home on an East Coast beach where Judy remembered the happiest times of her life. The atmosphere in my consulting room seemed very fluid.

Judy then said in an uncharacteristically soft way (unlike her frequent changes of subject after an interpretation), "I wonder what my experience in the womb was like, and what my life would have been like if I hadn't been induced." She now began to speak of her grandmother's summerhouse. "The summers in that home were the best part of my life. The grass was soft, and it was a big place with a lot of land and huge trees where I could climb. I was more on my own there than at home. My imagination felt free. I could be on my own and not be discovered. The house was like a castle with secret places. I felt really safe there."

For patients with premature, induced or caesarian births, the movement from inside the mother's body to outside can be viewed as a traumatic loss. Paul (1988) suggests that the patient may feel robbed or ripped off. Osterweil (1990) suggests that the patient can feel expelled. Certainly Judy felt mechanically pushed out at the end of the previous session. Such patients may attach in tenacious ways that may be difficult for the analyst to understand and endure. Breaks in analysis, as well as life transitions requiring separation and loss, will bring up the desire to remain in the womb along with the hatred and terror of being born.

After Birth

Winnicott (1975) emphasizes the period immediately following birth: In order for satisfactory development to occur, the baby needs a mother who can welcome the newborn and actively adapt to its needs. The baby needs a sense of continuity,

to be in a state of being. Winnicott postulates that if this does not take place, if the baby's mother is not available due to excessive narcissism, depression, or ill health, the baby will adapt by splitting off its own needs. A premature defensive and precocious use of mind occurs, causing rupture in the mind-body connection, often resulting in psychosomatic illness.

A young woman who came into treatment with me two years ago provides a dramatic example of this pattern. Among the reasons Linda sought treatment was a conflict about whether to get pregnant or to continue her studies. Some of her apprehension about pregnancy related to fear of being left by her husband if she was not advancing in her career. It became clear that her father's divorcing her mother had upset what she believed was an "ideal" family. Seeing her mother as quite helpless to function independently after the divorce made her fear pregnancy, even though she felt she would enjoy mothering and was reasonably secure with her husband. When she began to see that she could indeed function differently from her mother, she became pregnant within four or five months.

No sooner was Linda pregnant than she became very ill: vomiting profusely all day and unable to take in nourishment. She was exhausted and bedridden. She seemed to need to be a baby herself and to be completely taken care of and fed special amounts of baby food. In preparing to become a mother, she needed first to be a baby again. She had been the baby of the family, although the quality of mothering seemed geared to her mother's needs, not her own. At the time of the pregnancy, the poor quality of her own early mothering was still unconscious and thus somatized.

Nevertheless, she was more stable during the last months of her pregnancy and had a natural delivery. She described this as a powerful spiritual experience. The birth was a time of deep connection to her husband and a reclaiming of her body. Linda had been a dancer in her early twenties and was able, during the pain of labor, to dance to music to facilitate the birth. It is my guess that she had an easy birth herself and that both her own prenatal and postnatal periods were tougher.

Linda gave birth to Greta and took her home from the hospital the next day. Her husband took time off from work. The nursing went smoothly, and the three of them settled in. I did not know until she told me several months later, but Linda kept the house quite dark and allowed no visitors for at least three days (the period after birth that Winnicott sees as critical). Linda wanted the transition out of the womb to be gradual for her baby. I wondered what her own experience after birth had been. When visitors did start coming to the house to see Greta, Linda experienced it almost as a violent intrusion. Since Linda's mother was very socially oriented, I wondered if Linda, as a newborn, had felt impinged on by her mother's narcissistic need for many visitors. Perhaps Linda was protecting her baby the way she wished she had been protected.

The Birthday Anniversary Phenomenon

Another source of evidence that birth can be stored as traumatic memory is manifested in the range of affects that come around a birthday. I began noting this phenomenon with several female patients who described their husbands as emotionally distant around their own birthdays each year. The women all reported

that in the weeks before their husbands' birthdays, the men were depressed, provoked fights, and resisted making plans to celebrate. Each husband would either be ill or provoke violent conflict on the evening of the planned celebration. These men had no conscious memories of or curiosity about their births, although they described poor relations with their mothers.

After observing this birthday celebration phenomenon, the wives began to accept their husbands' discomfort at such times, to lower their expectations, and to avoid making special plans. This seemed to reduce the tension in the marriages at birthday times.

How is prenatal and birth memory stored? What kind of memory is it? Share (1994) has reviewed the literature on infant memory. She states:

> Recent and very significant research data . . . lend support to the possibility that the earliest affective and perceptual experiences/traumas can be stored in the unconscious, the conscious, or both, and are capable of retrieval in infancy, early childhood, and even adulthood. Additionally, researchers have tentatively located a place (the thalamoamygdala circuits) where such memories of affective experience may be stored and processed. (p. 142)

Linking Freud's ideas about types of memory with Terr's (1988) work on trauma, Share states that there are two types of memories getting clinical attention. "Burned-in" behavioral memory is one type of memory, which is comparable to Freud's perceptual memory; Terr's verbal memory is a second type, similar to Freud's memory image.

Share points out that authors such as Donald Spence, Ernst Kris and Scot Dowling – who insist on the impossibility of reconstructing specific infant memories – are referring to "verbal memory." This kind of memory becomes modified, distorted and overlaid with current experience and does not lend itself to veridical reconstruction.

Behavioral memory is traumatic, pre-verbal, intense and often re-enacted. The McGough Group of Irvine, California reported in the *New York Times* that this type of memory imprints on the amygdala. Large amounts of epinephrine and norepinephrine are released and may affect the indelible way this type of memory consolidates and imprints.

Share (1994) suggests that both types of memory are important in analytic work. "Using reconstructive and narrative approaches in working with these two types of respective memories, we could reach the human experience of our patients at the beginning while at the same time understanding the variations and developments that change such experience over time." (p. 143). Reconstruction is more possible from behavioral memory, which will be re-enacted and felt in the somatic countertransference. Behavioral memories will be present also in dreams. The narrative approach is more applicable to our work with verbal memory.

Birth Trauma and Classical Jungian Analysis

The dynamics of personal birth trauma may need special attention in the context of Jungian analysis. Patients with birth trauma have special problems navigating a transformational process. For example, while many patients in the *mortificatio* (psychological death) phase of an alchemical transformation process may feel a fear of death, birth-traumatized patients need special help to separate their feel-

ings and fantasies about death from the literal danger of death because of the traumatic birth imprint. Birth-traumatized patients often have somatic symptoms during the mortificatio stage and seek medical attention. Often there are feelings of impending catastrophe or doom that can be felt by the analyst in the countertransference. If the patient's terror can be understood and related to the birth or prenatal trauma, the depression and grieving related to the psychological death necessary in the mortificatio stage can be faced, and the patient eventually can move forward.

During the *separatio* stage of an alchemical process, patients with birth-related anxieties may feel persecuted by overpowering affects of being mutilated, cut up or forced out; separation is not seen as part of growth and individuation but as catastrophe. Separation anxiety may be acute before times of actual separation. If the analyst does not help the patient face these painful feelings, forward movement will be evaded and an impasse in treatment may occur.

Birth and/or prenatal trauma may even erupt in a *coniunctio* stage of an alchemical process. Bion (1966) has said that prenatal trauma can be split off successfully, only to manifest at any time in adult life. It does not manifest, necessarily, during infancy or early childhood.

Ruth, a patient of mine in her forties, dreamed that "she and her boyfriend were getting married and were at the hospital to adopt twins. At the hospital she found out she was one of the babies. The baby in the dream was like an egg out of a shell – an embryo, the dreamer wondered? It needed to hold her hand. It had a tiny arm that reached out and touched her finger." Ruth awakened from the dream shaken. It reminded her of how terrible her prenatal embryonic state must have been. Her mother told her that the night after Ruth was conceived, she realized how bad her marriage was – that it was doomed. The mother stripped naked, started drinking, and got hysterical. Her sister came to the apartment to calm her down.

The dream comes up at a time of making a new relationship. This patient has had a difficult time coupling with a man. Does this memory of her associations surface as she tries to couple and create a new relationship, reminding her of the rupture in the parental couple and in the mother-child bond? This dream may bring knowledge of the original trauma which, when integrated, will no longer need to be reenacted. In the dream, Ruth makes contact with the embryo, perhaps leading to a new life.

Maizels (1985) suggests that there is an ongoing conflict throughout life between those parts of the personality working to stay in the darkness of the womb and those parts wanting to change, to move forward into the light. His work on birth anxiety and the pull toward the womb may also help us take another look at the conflict between Fordham's and Neumann's description of the first year of life. According to Samuels (1985), Fordham describes an infant as being sufficiently developed to be capable of some separation from the mother after birth. Neumann postulates an extra-uterine year in which mother and baby are one psychologically. Perhaps both views are true. Parts of the personality a la Neumann remain merged with the mother in an in-utero or womb-like state of mind still unborn while other parts of the mind are born, go forward, and are separate from the

mother. What if both states of mind continue to coexist and conflict throughout life?

Concluding Remarks

Tustin (1988) warns us to be gentle in our dealing with mismanaged physical and psychological birth because we are dealing with elemental states that normally remain deeply buried and not investigated. There is an enormous sense of rawness and extreme vulnerability related to birth trauma. Trying to analyze such early states seems rather like trying to put a nightmare under a microscope; to write about such early states often seems awkward and clumsy but not to do so seems a professional dereliction.

When we talk about birth, we are talking about an experience that is both universal and deeply personal. It is both known and mysterious, physical and psychological, individual and archetypal. The physical process of birth affects the psychological birth process. The psychological process of either mother or fetus may affect physical birth.

When exploring this area of psyche, both analyst and patient may encounter intense pain and chaos in the transference/countertransference. Of necessity there will be periods of terror and waiting in the dark. These difficult analytic junctures are compensated by the patient's relief that the analyst attempts to understand where the patient is stuck, and is willing to traverse this difficult territory. There can also be moments of awe for both patient and analyst that the body and psyche hold these memories until we are ready to make the descent.

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