PSYCHOTHERAPY WITH INFANTS AND CHILDREN: PRE-NATAL ABUSE

by

William H Emerson

Her 28 month old son was shy, clinging to her skirts at the first appearance of a stranger. His eyes were furtive in their need for love, and expectant in their anticipation of rejection. She was despairing. Her husband had left her and her son two years earler. The few men that came into her lonely life, also came to know a screaming and insecure toddler.

He was, of course, not always that way -only when she started to show a real interest in the relationship. Her husband professed to love his son very much, and continued to seek as much contact with him as possible. But not without resistance. When he came to visit, his son was ambivalent, pushing him away as much as seeking him out. Why was this child so insecure about men, and ambivalent about his father, ? What had gone wrong? An independent psychological evaluation explored various factors. Was the current relationship between mom and dad pathological, and responsible for the boy's symptoms? Had the separation been traumatic for him? Were the mother's hostile feelings towards her ex-husband posioning her son's feelings toward the father, and men in general ? These and other questions were evaluated, and none found to be significant. Instead, the psychologist (who was not trained in prenatal psychology) noted that the boy's "attitude" towards strangers and the father seemed to exist "even from birth", and may have been due to either hereditary or characterological factors.

Since the smptoms were present from birth, another cause for them was considered, i.e. prenatal trauma. A sand-tray diagnostic was done (children created pictures of their unconscious conflicts and traumas via manipulating objects and sand in a sand-tray). He identified himself with the figure of an in-utero and battered foetus. With my assistance, he was them regressed to the prenatal period, where he experienced himself being screamed at, beaten, and tortured. When his mother was told of hs experiences, she broke down in tears, sobbing, "Oh my poor little boy . . how did he know; I never told anyone, even my husband . . . how did he know? . . . .please don't tell anyone; I don't want his daddy to know . . ."

The real story then emerged.

While pregnant, she had had an extramarital affair with a man. He had threatened to "beat the life out of her if she fdidn't leave her husband and marry him. He did just that, physically abusing her on several occasions, with severe blows to the uterus, face, and body. The little toddler experienced this abuse during four sessions of regression therapy. He catharted his feelings in the presence of compassionate and caring adults - his mother, father, and myself. His symptom patterns (stranger anxiety and paternal ambivalence) changed abruptly after these sessions. He is now four years old, psychologically healthy, and showing no signs or side-effects of the physical abuse.

Others are not so fortunate. Statistics indicate that one out of four girls and one out of eight boys can be expected to suffer sexual abuse by the age of 16. Statistics for physical abuse are even higher. And both statistical categories leave out an important part of the abused population, i.e., unborn children. As is obvious from the case described, when expectant mothers are sexually or physically abused, their unborn children also suffer from the abuse. How can parents or professionals tell whether an unborn child has been abused? What are the signs and symptoms of such abuse? How can these children be treated? What children are "at risk" for prenatal abuse? Answers to these questions are published in pamphlets, available from this author.

Prenatal (i.e. unborn) children are extremely sensitive and perceptive with respect to their immediate and remote worlds. For example, one three year old while regressed to the womb) told me about his mother's secret ideas of aborting him, and experienced therapeutic catharsis around the alleged event. When I asked his mother whether she had had such ideas, she guiltily admitted to them, but was relieved that they had come out in the open. Whether this child was psychic, had overheard his mother talking about aborting, him, or had accurately remembered a prenatal even (i.e. maternal abortion ideation) during his regressions are all possible eplanatations for his therapeutic experiences. For reasons too complex to describe here, the latter appears to be the most plausible explanation in this case. The only traumatic material which emerged during his sessions had to do with abortion, and the concomitant fears of annihilation, destruction, and loneliness. The sessions significantly improved his relationship with his mother, and increased his sense of security and safety in the world.

In my clinical experience with infants and children, a number of prenatal and perinatal events have proven to be traumatic. The most frequently occurring is birth. Others are biological (unwanted or threatened) conception, abortion ideation or attempt, death of an in-utero twin, family crises (separations, divorces, illnesses, deaths, financial difficulties, sexual dysfunction, etc.), substance abuse of the expectant

mother, material illnesses or toxicities, physical and/or sexual abuses of the mother, pre and post-maturity, and circumcision. This list is not inclusive of all tgraumas, nor is it true that the events are necessarily traumatic for all who are exposed to them A specialized therapy has been developed to treat these traumatic antecedents. This therapy is normally supervised by a trained professional, with the close assistance of parents or those closest to the infant or child. In many cases, the trained professionals are (in order frequency): obstetric nurses, midwives, massage therapists, primal therapists, chiropractors, osteopathic physicians, child birth educators, homeopathic physicians, reichian therapists, rebirthers, obstetricians, psychologoists, mfcc's and pediatricians. More and more, these professionals function as consultants to the parents, who do the work under close supervision and guidance. The results of these treatments have recently been reported in Aestheme (the Journal for the International Primal Association). In general, medical and/or psychological symptom patterns change dramatically, sometimes after as few as two or three sessions. In addition, projected patterns of psychopathology or dysfunctionality do not develop (infants have been followed for up to 12 years), and positive results on personality and development have also been noted.

Of the potentially traumatizing events which were listed above, the only unavoidable circumstance is birth. Both C-seciton and vaginal births hae proven to be traumatic, and most children appear to experience at least some traumatization while being born. Ninety per cent of a sample of 200 children showed signs of minimal to mild birth trauma, and 55 per cent showed signs of moderate to severe traumatization. For this reason, it is particularly important that birth be dealt with therapeutically.

Publications to assist the professional or parent in the therapeutic process with infants and children, and information regarding training sessions are available from this author.

CONSECRATED HENCEFORTH TO SERVICE

My loss and defeat was their gain and success.
Their share will increase because mine has been less.

I like to think still I can reach out and bless
other lives; and that none of those faces that press
around me in throngs to receive in largesse
contentment and joy from my hands ever guess
that I give day and night what I do not possess.

Ann Keith