HEALING OF PRE- & PERINATAL TRAUMA

POINTS OF VIEW

Prebirth Memory Therapy
Including Prematurely Delivered Patients

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ABSTRACT:

This paper focuses on the psychological aspects of prebirth and perinatal memories encoded for full term and premature infants and activated as possible pathology during adult life. It presents a brief recapitulation of the basic hypothesis that not only do human beings inherit the genetic coding of their mother and father, but also the mental and emotional states of their parents in the form of non-conscious emotional reaction patterns from the nine months of gestation including birth and post birth circumstances. The anxiety and stress of full-term delivery or premature labor for the mother, and the heightened emotional levels of the midwife or delivery team, contribute to an emotional reservoir from which the baby draws as it grows and develops in life. By recognizing the source of this reservoir, persons can stop blaming themselves, parents, governments, and/or God, and assume responsibility for their own lives.

INTRODUCTION

The Whole-Self method discussed in this paper"the means by which data are elicited from the client--incorporates the Prebirth Analysis Matrix (PAM) used to help people re-experience twenty-two specific moments during the prenatal and perinatal period, including time in the crib or incubator. Each point in what we call the emotional DNA is related to specific mental, emotional and physical reactions synthesized from the parents. We will each begin with a comment, and then jointly discuss the method.

JON TURNER:

I am terribly lonely and most of all feel fear! My hands are wet and I can hardly breathe. There is fear I will die if the incubator is not there. I think I cannot live alone. The fear of living! My breathing goes faster and faster high in the chest. I am seized with panic! I will die! I am imprisoned!

Pat used these words to describe her feelings as a premature infant lying in her incubator. When she retrieved and re-experienced these feelings, she realized that these words were not just those of a little baby. She also was describing feelings that had followed her throughout life.

In my practice, I started getting referrals from therapists who had given up on certain patients. The inspiration came to me that these patients might heal rapidly if I were to regress them back to experience the emotional patterns of their father and mother during the nine months of gestation. By focusing on the 22 specific moments in the gestation, these patients discovered that they were not guilty; they had done nothing wrong. They were able to recognize that the unresolved, nonproductive and diminishing emotional patterns they were experiencing were actually synthesized from the patterns of their parents during the period of gestation. In other words, they discovered that not only do we synthesize the genetic coding of our parents but their emotional DNA as well.

TROYA TURNER:

Trying to project back to my birth, I suddenly saw my mother sitting in her doctor's office. And I heard the doctor saying: "Because of this problem with your tipped uterus, expect that this first baby could be born dead!" At that moment, I realized that my expectation was that I would be born dead. I experienced my mother's reaction to his words. Her feelings of fear, panic and disaster became a very familiar reaction in my own life. Most startling of all, in this recollection was the realization of the cause of my tendency to sabotage good things about to happen in my life. For 12 years, anorexia and bulimia eating disorders were my nonconscious way of fulfilling the expectation that I should be dead.

Fifteen years later, when I told this story to Jon, he asked me if I had ever discussed my vision with my mother. I admitted that I had not. So, the next time we went to visit my parents, I told them what I had seen in my imagination. My father immediately denied it. But my mother calmly asked: "How did you find out what the doctor told me? I never even told your father what the doctor said." So it was confirmed. The thought that created my pathology and my mother's reaction to those words had been generated before I was born. Seven years ago I was attending a psychology conference in England when I heard Jon Turner lecturing. He was teaching the same ideas that I had used to heal myself! Two years later we started working together.

WHOLE-SELF HYPOTHESIS

The basis of our whole-self therapy is that each child is the synthesis not only of the genetic DNA coding of parents but also of their mental and emotional states during the nine months of gestation. In other words, whatever the mother and father experienced at that time becomes part of the emotional repertoire of the baby. As the child's body is gestating, so too, are emotions being developed and practiced so that by the time of birth there is a range of emotions that the baby can feel. These feelings may not be expressed in words by the newborn, but that does not mean they are not there.

In 1990, we attended a meeting of the Forum on Maternity and the New Born at the Royal Society of Medicine in London (Zander 1990). We saw videotapes of three-day-old infants expressing obvious emotions in interactions with their mothers. These emotional reactions not only are experienced by very young infants, but can also be experienced and remembered from the nine months of gestation, using various methods.

The whole-self format is called the Prebirth Analysis Matrix (PAM). The PAM helps any person to discover specific emotional patterns synthesized from their parents. In effect, through the twenty-two PAM questions, each person is able to decode and (when they wish to) change their emotional DNA.

PREBIRTH MEMORIES

There is an obvious question to ask at the outset: Is it possible that most infants are aware of the intra-psychic and interpersonal activities taking place during their gestation? Mr. David Boadella (1986) of the London Centre for Biosynthesis has acknowledged that in the field of prenatal and perinatal work, there is a significant problem because of our inability to elicit verbal testimony from babies. Nevertheless, he believes that there is a nonverbal language in the body that can be recovered and expressed. This is what we have been doing with the Prebirth Analysis Matrix with thousands of people since 1970. They have meaningfully re-experienced and verbalized information from the prenatal period and have been able to use this information as a significant source of life-long feelings and emotional and reactive patterns.

Psychologist David Chamberlain, Ph.D., in his landmark book, The Mind of Your Newborn Baby (1998), offers a clarion apologia for newborns as real persons:

Now science confirms that infants are social beings who can form close relationships, express themselves forcefully, exhibit preferences, and begin influencing people from the start. They are capable of integrating complex information from many sources and with a little help from their friends, begin regulating themselves and their environment.

Do these capacities for a "warm start" suddenly turn on like a computer when we take our first breath? Obviously not! Just as gestation is the period for my little body to develop and grow, this nine months is for my emotional capacities to develop, grow, and be practiced. In other words, my body and my emotions were in parallel development to work in synchrony at birth.

PREMATURE DELIVERIES AND CHILDREN

In their 1991 paper, Bleton and Sednaoui-Mirza offer an overview of the literature on emotional psychic influences of the mother and father that might influence delivery, specifically premature delivery. They hypothesize that the unresolved psychic positions of both the mother and the father toward their parents and toward each other may be factors resulting in a shortened pregnancy.

Our studies suggest that prematurity and its subsequent pathology can be the result of the intrapsychic and interpersonal activities of the parents during the pregnancy. The whole-self hypothesis holds that all of the parent's feelings during pregnancy, pathology-generating or benign, could be the source of the child's recurrent feelings.

Whole-self work is basically an holistic, transpersonal therapy, recognizing there are aspects of each person that cannot be explained by empirical evidence alone. We believe this approach is often effective and meaningful because it explores not just the mind but the interconnectedness of all parts of the person: physical, mental, emotional, and spiritual; that is, the whole self.

AN EXPERIMENT

We mentioned the ease of recovering data from this nonverbal pre- and perinatal period. Perhaps you would like to try an experiment yourself in working through what we call your whole-self. We define the Whole-Self as that part of each person which knows everything that the individual's consciousness has ever experienced either consciously or unconsciously. In this experiment, the Whole-Self is asked to let you experience the answer to the questions. The answer may be experienced through words that describe the feelings (some people see written words, as if they were on a page of paper or television screen). Most adults actually feel the answer in their own body, as in their days as an infant, and then use words to describe those feelings. Others will just "know" the answer. It can be productive to write down the answers you are given for later exploration.

After each of the following questions is read, close your eyes and pause to let yourself experience the answer. The first intuitive reaction is the answer, so please just allow an answer to come to you, without thinking. Sometimes no feeling is the answer. If you get an answer that feels uncomfortable, please do not change it until you have explored it. Before you begin, please close your eyes for a moment and become aware of how you feel. This can be accomplished most easily through watching how you gently breathe in and out several times.

Now I would like your Whole-Self to take you back to the time after your birth when you are in a crib or, if premature, in an incubator. I would like your Whole-Self to let you experience the emotional feelings you are feeling as this newborn infant in the crib or incubator. Question: Are these familiar feelings in your life? Yes or no?

As this newborn infant, I would like your Whole-Self to let you experience what are your emotional needs-not your physical needs, but your emotional needs. Question: Are those still your emotional needs today? Yes or no?

Thank your Whole-Self for giving you these answers. If it feels comfortable to do so, briefly share your experiences with another person.

REVIEW

When we ask people to focus on the feelings experienced in the crib or incubator, there are several words that almost everyone mentions: cold, alone, isolated, abandoned, rejected, shock, helpless, hopeless and powerless. People who are very mental at the expense of the emotions make conclusions such as, "I am out of control!"; "No one loves me!"; "Mother abandoned me!"

We find that when people have feelings they do not like, they naturally tend to oppose, resist, deny or suppress those feelings. We say that this creates the Law of Opposition: "Whatever I am opposed to, I have to experience!"

When people are opposed to what they are feeling, at a non-conscious level they make judgments against themselves. The most frequently mentioned self-judgment words are: unlovable, unworthy, worthless, unacceptable, insupportable, not good enough, inferior, inappropriate, bad, wicked, terrible, horrible, despicable, disgusting, dumb, stupid, inept, incapable, incompetent, incomplete, insecure, helpless, hopeless, or powerless. These self-judgments trigger the Law of Confirmation: "Whatever I really believe about myself I will keep proving to myself!"

CASE HISTORY I

John-Raphael Staude, transpersonal psychologist and Director of Proteus Institute in California, reports a case in which he used the Prebirth Analysis Matrix (PAM). With his permission, here is a brief synopsis of his case, which he called The man who could not stop running.

R. was in his mid-50s and presenting an array of definable pathologies including depression and paranoia. He had a sense of never having a home, even when he was married and had children, and of not being able to be in a partnership. In addition, he always felt compelled to run when he was successful in his career. He had an obsession about his mother and all the women he had pursued in his life.

R's reported history described how his mother, an artist from New Orleans, became pregnant during a passionate affair with a musician. Abortion being illegal and otherwise not possible because of her Roman Catholic religion, she fled to New York City in shame, unable to tell her parents about the pregnancy. This move apparently encoded into R. the pattern of running away. When her shame became unbearable, she got an unethical doctor to deliver the baby two months early.

R., in his PAM session, was able to describe and relate very specific moments and feelings of his mother during the passion of the affair; the devastation of learning that she was pregnant; the feelings that precipitated her running away; the shame, humiliation and fear of people seeing her pregnant and knowing that she was unmarried; the fear, terror, and panic over having this unbearable thing growing in her belly (R, slightly overweight, has a belly which makes him look pregnant when emotional pressures build); the terrible conflict of having the baby removed from her to erase her shame. R was in an incubator for almost two months. He experienced the feeling that he could never connect with any woman, including his mother, who had never connected with him before or after the birth.

When R. was two, the mother married and legally adopted R. but delegated his upbringing to others just as she had done before the marriage. It was not until R. was an adolescent that his mother told him the truth about his parentage.

R's mother once took an extended trip to Europe and left him with his stepfather. At that time, the stepfather began to rape and sexually abuse R. This went on until R.. was eighteen and felt strong enough to forbid it. After that he attempted several gay relationships, but found them unsatisfactory. He then started to pursue women but found this to be an equally unfulfilling behavior. R. was simply incapable of transcending the patterns in relationships and sexuality first experienced by his mother during his gestation.

Even though he was brilliant in college, R. was never able to feel self-worth and self-esteem. He did not feel connected to his marriage, children and lovely home. He started running away. Like his mother, he was attracted to Europe.

A long history of prematurely terminated therapies left R. ever more deeply depressed and despondent. However, after meeting John-Raphael at a breathing workshop, he expressed a desire to explore more deeply his birth. Therapy began, using the Prebirth Analysis Matrix.

After seven months of a mix of gestalt and psychosynthesis therapy in which progress was being made, R. suddenly terminated the sessions and ran to another country. Two years later, John-Raphael received a letter from R. with photos enclosed, showing R's house and the woman with whom he had been sharing his life. Although confessing that he still occasionally experienced some bouts of depression, R. stated that he was not running away as before. The key to his stabilization had been discovering that the source of his

behavior patterns lay in his mother's and father's emotions and behavior during the time of his mother's pregnancy. He was able to recognize that he had been living out the behavior patterns of his mother. Having recognized this, he was able to begin disassociating from them and to start controlling his own life.

CASE HISTORY II

A 49-year-old woman, S., had medical problems in nearly every part of her body except her spleen. She survived a cancer of the pancreas 25 years ago and is overcoming a recurrence. This woman had been conceived following a seven-year, very sexually charged and passionate relationship between her father and his mistress. At the moment the pregnancy was discovered her mother was "enormously happy"; her father was very proud of what he had done. Later his wife forced him to close off emotional support to his mistress during the pregnancy. This trauma created a deep depression that triggered three suicide attempts during the pregnancy. Not only that. The wife actually tried to murder the mistress. During the PAM session, the daughter of the mistress got in touch with deeper levels of her origins:

My father is feeling "enormously intoxicated" when he makes love with my mother. [Note: S. was an alcoholic between age 20 and 35]. Father is desperate to be one with her. Mother is feeling a lot of anxiety and a lot of manic, desperate joy. She has also a deep, deep sadness and fear of abandonment.

During the pregnancy a meeting of the wife and the mistress has the tension and drama of a Verdi opera. S. continues:

The wife comes in and accuses mother of nasty things. Mother can't breathe. She feels seared. She is confused as to whether to feel guilty about the accusations. She is tossed in confusion but is determined to have the baby. She judges herself unworthy, worthless, unacceptable, insupportable, bad, terrible, horrible, despicable and helpless, hopeless and powerless. She wants to die but she wants the baby.

Next, S. discovers why the wife hates her mother so: the whole country knows of the notorious affair which produced this illegitimate baby! Not only is shame and humiliation locked into S., but also the fear that women are dangerous, that they can kill. The trauma narrative intensifies: Mother is being hit on the head! She is completely taken aback! Her heart stops! She is falling to the floor in shock!

Father is visiting her one night and apologizes to mother for his wife's behavior. His wife threatens him: "If you see her [S's mother] or the baby you will never be able to see our children again!" Everything stops for mother! She is not afraid but she does not want to breathe! Nothing matters! It is a very familiar feeling for me! Specifically, everything stops! Like being dead! What is alive is in such pain that mother wants to kill it because it hurts so much! She is swallowing a lot of pills to kill herself. It is a very strange feeling!

I want to be killed too! I am very disappointed that we are saved! I feel very egotistical not about mother but about my own feelings! Now, I feel nausea! [As the first contraction strikes] Mother screams in fear and panic, I won't be able to make it!" She feels helpless, hopeless and powerless! Extreme pain for her! She is suffocating and cannot breathe! She is writhing and screaming!

Then he came to this astounding insight!: Just before I draw in the first breath my whole life flashes in front of me like an instant replay! I am not going in there! [S. screams.] I get very, very stubborn! I do not want to be born! The pain is mother's! All the fear, terror, panic, abandonment, etc. are hers! I resist for two days! I refuse to be born! After two days mother is dead! I remember looking down at her! I feel that this will go on forever--that she will just keep on dying over and over! It is so horrible, I do not want to see!
The adrenaline shots work! Mother starts breathing. The delivery starts again! I see her there on the table! Everyone is rushing around mother! No one is paying any attention to me! I'm afraid! Mother is not paying attention to me!
I ask S.: What does a person get when they are in medical crisis? S. responds: "A lot of attention!" Now S. has understood her prenatal and perinatal inheritance ("In the crib I feel alone--so very alone! I feel very wrong! I should be with my mother!"). Her constant medical crises were not just on a mental level but on all levels of her body, mind, emotions, and spirit. She was, at last, ready to begin the healing process.

NEONATAL INTENSIVE CARE UNIT

There is another area I would like to touch on briefly-the neonatal intensive care unit (NICU) and the treatment of premature babies. The research of W. Ernest Freud (1988) and Helen Bender (1988) presented at the 8th ISPPM Congress in Badgastein, Austria is pivotal on this subject. Attention also should be given to studies conducted by Dr. Ruth Rice (1989). At the 9th ISPPM Congress in Jerusalem, Israel, Dr. Rice reported on studies of teenagers who had been in incubators after they were born. Over 50 % had marked to severe emotional psychological pathology due, in her view, to the inordinate abuse inflicted on premature infants in NICUs. Studies show that infants in such circumstances experience invasions of needle pricks, intrusions into body openings, generally intense pain, interruptions of rest and sleep about 100 times every 24 hours"all caused by intrusions of medical staff. High levels of continuous noise from equipment and intense light creates additional abuse. Just being touched often triggered a medical crisis. Dr. Rice proved that it was not the touching causing the crisis but the infant's associations with human hands associated with pain. Such pervasive, unrelenting pain induces a helpless, hopeless and powerless state in which the infant gives up. When incubation lasts for many months, bonding with parents becomes difficult and sometimes impossible. Fortunately, we are seeing an increasing awareness of the benefits of the "kangaroo" method of breast feeding by mothers of infants in NICUs.

CONCLUSION

These two cases support the hypotheses that not only is there a synthesis of the genetic coding of the parents but that there is a merging of their emotional/mental patterns which in some way constitutes the emotional base of the newborn. Dr. Alessandra Piontelli (1992), in her pioneering ultrasound research, has proven that as early as 13 weeks the fetus is showing individual behavior and personality traits that continue on after birth. Prebirth Memory Therapy with its Prebirth Analysis Matrix provides a practical and powerful means of tracing unhealthy reactions and behaviors to their origins before birth.
The great importance of birth conditions in shaping the life of individuals and of society was eloquently stated by Peter Fedor-Freybergh (1992) in his Presidential Address at the 10th ISPPM Congress:
A woman does not get pregnant because she has a womb, but the womb mediates the primary urge of reproductive function. In a philosophical sense, consciousness precedes being and not the other way around as Marxist theorists believe. Consequently, if you want to create a healthy, non-violent, creative human being, or society...one has to guarantee the most optimal conditions possible at the very primary stages of development. Only then can we achieve a true primary prevention of illness, mental, emotional and physical disturbances, hate, intolerance, violence and war in the individual and society.
Although there is much that needs to be changed in the medical treatment of infants in NICUs, we would like to conclude with words from Pat, noted earlier in this paper, who was born two months premature. After Prebirth Memory Therapy, Pat sent us a letter entitled Back to the Incubator.
During the course of my PAM the negative circle got broken. First of all I was advised by you to breathe slowly and bring my breath down low into my belly and to realize that I am here -alive! I completely realized that I did it! I am alive so I am strong enough! I knew and I know that I can make it alone, on my own legs!
I also see that it comes out of this prebirth period why I have not been able to stand glaring light and much noise. The loneliness, the sorrow, the fear to live, the fear to die, the lack of interest in life and other people that I was born with was underlined by the incubator and during my life it seems to have become stronger. In PMT, when I recognized the reasons and purpose for my life and took responsibility for it, my life became interesting and full of sense and friendship. I experience now the joy of living.
I believe now that it was this very loneliness out of which grew my desire. This desire makes me a seeker. I long to find the deepest meanings of life where there is no fear, no loneliness, no death. There is where we are one in love!

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POINTS OF VIEW

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THE VULNERABLE PRENATE

INTRODUCTION

The prenate (i.e., the unborn baby) is vulnerable in a number of ways that are generally unrecognized and unarticulated. Most people think or assume that prenates are unaware, and seldom attribute to them the status of being human. I recall a recent train trip, where an expectant mother sat in a smoking car filled with boisterous and noisy people. I asked her whether she had any concern for her unborn baby, and whether she thought the smoke or the noise would be bothersome to her unborn child. Her reply was, "Well of course not, my dear. They are not very intelligent or awake yet." Nothing could be further from the truth. Theory and research from the last 20 years indicates that prenatal experiences can be remembered, and have lifelong impact. The major purpose of this article is to clarify the conditions under which prenatal experiences may be lifelong and to describe the theoretical and research perspectives that are necessary to understand the effects of prenatal traumatization. In addition, because the incidences of personal and societal violence are at an all-time peak and headed higher,

INTERACTIONAL TRAUMA

The effects of prenatal traumatization cannot be predicted without knowledge of other factors, and prenatal experiences are likely to have lifelong impact when they are followed by reinforcing conditions or interactional trauma. The term interactional trauma means that traumas interact with each other in producing their effects. In statistical analyses, interactional means that the effects of factors depend on the presence of other factors. Both of these definitions communicate the meaning of interaction as it is used in this article. For example, it is unlikely that being stuck during the birthing process causes claustrophobia during adulthood. However, claustrophobia .is more likely if similar, reinforcing traumas occur.

In one such case that I treated, a baby who had been stuck during his birth was also locked in a closet for 24 hours as a child, and held and choked by his brother on several occasions. Several points are relevant here. First of all, prenatal traumas provide 'tinctures" for later experiences. Stated differently, life experiences are perceived in terms of prior and unresolved traumas. When a baby is stuck during birth, the baby is likely to perceive later events as entrapping, or to unconsciously manipulate or choose life situations that bring about entrapment. This process is called recapitulation. Secondly, similar or recapitulated events, independent of perceptual processes, are likely to reinforce prenatal traumas, resulting in relatively chronic symptoms. In the case of the baby just described, childhood events acted as reinforcements for the birth trauma, resulting in chronic claustrophobia.

THE EFFECTS OF PRENATAL EXPERIENCES: PRENATES ARE CONSCIOUS AWARE BEINGS

During the 1995 APPPAH Congress in San Francisco, David Chamberlain shared a case that exemplifies the consciousness of prenates. In this case, a baby was undergoing amniocentesis. Videotapes of the amniocentesis showed that when the needle was inserted into the uterus, the baby turned toward the needle and batted it away. Thinking that they had seen an aberration, medical staff repeated the needle insertion, and again, the baby batted the needle away. There are other anecdotal reports that babies routinely withdraw from needles as they are inserted into the uterus. From these observations, it is safe to conclude that babies are very conscious of what is happening around them, particularly with respect to events that have impact on them personally.

In her book From Fetus to Child, Alessandra Piontelli cites several cases of prenatal awareness. She describes a twin pair, at about four months of gestation, who were very conscious of each other, and had periodic interactions. One of the twins was actively aggressive, the other submissive. Whenever the dominant twin was pushing or hitting, the submissive twin withdrew and placed his head on the placenta, appearing to rest there. In life, when these twins were four years of age, they had the same relationship. Whenever there was fighting or tension between the pair, the passive twin would go to his room and put his head on his pillow. He also carried a pillow and used it as his "security blanket,' resting on it whenever his twin became aggressive. From this and other

research (such as David Chamberlain's Babies Remember Birth, and Elizabeth Noble's Primal Connections), it seems clear that prenates are conscious beings and that behaviors that begin in utero are also likely to carry over into later life.

PRENATAL EVENTS ARE REMEMBERED

For years, it was hard to understand how prenatal experiences could be remembered. The central nervous system is very rudimentary during the prenatal period, and is not fully myelinated (covered by a protective sheath). However, anecdotal reports of adults regressed to the prenatal period and remembering prenatal events are common in primal and regressive communities. In 1970 Graham Farrant, an Australian medical doctor, began experiencing prenatal events and recording his body experiences. He was quite astonished to discover that he experienced most of his significant prenatal memories at a cellular rather than a tissue or skeletal-muscular level, and he referred to his recollections as cellular memory. In 1975 Frank Lake, an English theologian and psychiatrist, found that prenatal memories stemmed from viral cells, that viruses were primitive prenatal cells that formed during trauma and carried traumatic memories. He consistently referred to prenatal memories in terms of cellular memories. Over the last five years, there has been a considerable amount of research done in cellular biology, all of it supporting the theory that memories can be encoded in cells. The research of Dr. Bruce Lipton, reported in the 1995 APPPAH Congress, is relevant here and supports the conclusions of Farrant and Lake.

PRENATAL MEMORIES MAY BE THE MOST INFLUENTIAL

A group of European psychologists, led by R. D. Laing and Frank Lake (both now deceased), contend that prenatal memories are the most influential because they are the first. This perspective is apparent in Laing's book The Facts of Life, where he srites, "The environment is registered from the very beginning of my life; by the first one (cell) of me. What happens to the first one or two of me may reverberate throughout all subsequent generations of our first cellular parents. That first one of us carries all my 'genetic' memories" (p. 30). He goes on to say, "It seems to me credible, at least, that all our experience in our life cycle, from cell one, is absorbed and stored from the beginning, perhaps especially in the beginning. How that may happen I do not know. How can one cell generate the billions of cells I now am? We are impossible, but for the fact that we are. When I look at the embryological stages in my life cycle, I experience what feel to me like sympathetic vibrations in me now...how I now feel I felt then" (p 36). Frank Lake mirrored Laing's perspectives. Lake contended that the most formative experiences were ones that occurred prenatally, especially during the first trimester. In the U.S., Lloyd deMause has also written about the social, cultural, and political influences of prenatal experiences, and reported on these findings during the 1995 APPPAH Congress.

PRENATES INCORPORATE PARENTAL EXPERIENCES AND FEELINGS

From his regressions with adult patients, Lake also found that the most influential events were maternal experiences that passed biochemically through the umbilical cord by means of a group of chemicals called catecholamines, but it is also true that prenates incorporate psychic prenatal feelings and experiences, especially those of their mothers. Maternal emotions (and paternal emotions through the mother's emotional response to them) infiltrate the fetus. Research shows that what mothers experience, babies also experience. A good example is the following case. A woman's father died just prior to the conception of her child. She spent the whole nine months feeling depressed and grieving the loss of her father. If it is true that babies experience and remember what their mothers experience, then her baby should also have experienced loss and depression, and these feelings would be expected to resurface during childhood and/or adulthood. This appeared to be the case.

As a child, her baby was periodically depressed, and medical personnel could find no physiological or psychological basis for the depression (They were not cognizant of the child's prenatal experiences). When the child was depressed, he would draw pictures of old and dying men in caves (in pre- and perinatal psychology, caves are symbolic of wombs, the place where he experienced the loss of his grandfather). After drawing, he would feel better for a while, but the depression would slowly return. He was not conscious of any connection between his drawings and his grandfather's death. The depression became chronic when his parents were experiencing tension (his mother and father were living separately but raising him together). The tension symbolized the loss of his father and grandfather. His drawings sometimes depicted a little girl frantically searching for dying men. The little girl probably represented his own feminine, the mother's inner child, and/or a female twin's experience of the grandfather's loss. It is unlikely that grief would have resurfaced as chronic depression without the reinforcing conditions of father loss and parental discord.

It is important to realize that although prenates do take on the prenatal experiences of their parents, they also have their own unique experiences during the prenatal period, independent of their parents. The mechanisms of how this works are not clear, but numerous anecdotal reports and clinical cases show that prenates have their own experiences. For example, I recall the reports of a regressed child, a twin, who was repeatedly subjected to verbal and physical fights between his mother and her boyfriend during the prenatal period. He reported that his mother and her boyfriend were constantly fighting, but he and his twin would respond to this by cuddling up and rocking while the fighting went on. During the fighting, they both felt quite clever (to have avoided the tension) and relaxed. Perhaps the presence of a comforting twin can make separation from parental experiences easier.

WHEN REINFORCED, PRENATAL EXPERIENCES MAY HAVE DRAMATIC AND SYMPTOMATIC INFLUENCES

In the case of the woman who lost her father just prior to pregnancy, the baby presumably experienced the same loss that his mother experienced. In addition, a very tangible and personal trauma happened shortly thereafter. Early in the pregnancy, when she was eight weeks pregnant, the mother's husband abruptly left her for another woman. She was shocked by the experience and felt deeply abandoned. Presumably her unborn child felt abandoned as well. Because the woman had little financial security and did not want to raise a child by herself, she decided to abort her child.

She attempted several abortions, most often by using the hooked or curved end of a coat hanger. As a child, her baby was periodically sadistic and self-destructive. The manifestations of his sadism bore a striking resemblance to his mother's abortion attempts, although he was consciously unaware of them. He burned himself with cigarettes and gouged private parts of his body with sharp metal objects. His favorite sadistic instrument was a fishing hook, but he complained he could never buy ones that were big enough. As a young adult he was arrested thirty times for assault, and his modus operandi was reminiscent of his mother's

attempts to abort him. He usually assaulted his victims when they were sleeping, by using heavy braided wire with a wire hook welded on the end!

Aggression and Violence are Pathological Symptoms Resulting from Multiple, Reinforcing Traumas with Themes of Loss, Abandonment, and Aggression

In the case just described, the prenate experienced the intense loss and abandonment that his mother experienced. In addition, he also experienced the abandonment that comes with parental narcissism, (i.e., his mother was so absorbed in her abandonment and loss that she had little or no cognizance of him, nor did she have time or energy to celebrate his presence). On the contrary, he was perceived as a burden, and as something to get rid of Consequently, he also experienced the aggression of his mother's abortion attempts on his life.

PRENATAL AND BIRTH TRAUMAS ARE MIRROR IMAGES

Prenatal traumas have two distinct impacts on birth. First of all, birth is often perceived and experienced in terms of prenatal traumatization. For example, babies who experience abortion attempts are also likely to experience birth as annihilative. Babies who experience near-death during implantation in the womb are likely to experience birth as a near-death experience. Babies who experience aggression or violence while in the womb are likely to experience the interventions of birth as aggressive and violent, even though there may be no such intent on the part of medical personnel or parents.

Secondly, as Sheila Kitzinger has documented, whenever there is significant prenatal stress (trauma), there is an increasing statistical likelihood that birth complications will occur. The greater the degree of stress or trauma during the prenatal period, the greater the likelihood of birth complications and obstetrical interventions. This is exactly what occurred in case of the mother whose father died just before she became pregnant, and who attempted several abortions. The mother had a very difficult birth with long labor and many complications. Many interventions were used and repeated, among which were inductions, augmentations, sedations, analgesias, anesthesias, forceps, episiotomy, intensive care placement, and respiration.

It should be pointed out that the severity of symptoms in the present case is due to the additional and reinforcing traumas, all involving loss, abandonment, and aggression. When the baby was three months old, the mother took him shopping in a stroller, forgot that he was with her, left him in an aisle of the store, and only realized her error hours later. In addition to this, she had a boyfriend who was repeatedly and physically abusive with her son during his early childhood. These multiple and reinforcing traumas manifested in his childhood and adulthood as aggression and violence.

PRENATAL AND BIRTH TRAUMAS IMPAIR BONDING AT BIRTH

In addition to posing a risk of birth traumatization, prenatal traumas have another and more insidious impact. When traumas occur prior to or during birth, the quantity and quality of bonding is radically reduced. This reduction occurs for two reasons. The first has to do with the defensive dulling of mind and body, a natural defense against (Bloch, 1985). This self-anesthetization occurs because of the hormonal changes that normally occur in the body during and after trauma and shock. When the body and mind are dulled, and when the body is exhausted from stress, the quantity and quality of bonding are lessened.

The second impact has to do with the failure of parents and others to acknowledge traumatization, which diminishes the bonding process even further. When traumas occur, there is a critical period of time afterward during which humans require understanding, acknowledgment, and compassion in order for shock to subside and healing to begin. However, it is rare for babies to receive understanding, acknowledgment, and compassion after their prenatal and birth traumas, simply because no one knows or believes that traumas have taken place. As has been verified in my own clinical research with babies, unacknowledged traumas create distrust in babies, and this significantly impedes the bonding process. In contrast, it is informative to witness the level and depth of bonding in babies who have not been traumatized, or whose traumatization is being seen and acknowledged. The bonding is noteworthy by its depth, intensity, and duration. One only has to witness such bonding to realize that bonding is significantly reduced and altered by the presence of unacknowledged and unresolved traumatization.

Lack of Bonding Predisposes the Individual to Aggression and Violence In my work with infants over the past 25 years, I have discovered some important interrelationships between prenatal trauma, birth trauma, bonding, and aggression. The first interrelationship is that birth actively impairs the bonding process because many aspects of the birthing process are psychologically and physically painful for babies. Medical exams and medical tests are often experienced by babies as unnecessary, invasive, and painful, and this is rarely acknowledged. Medical personnel routinely separate babies from parents after birth, and separation is often experienced as terrifying abandonment.

Placement in intensive care is frequently experienced as terrifying, lonely, overstimulating, and painful abandonment. Anesthetization is particularly impactful on bonding because residual amounts of anesthesia are common in babies, even hours and days after birth, and anesthesia makes babies (and mothers) numb and therefore less available to the bonding process. Epidurals were thought to be superior to other anesthetics because they would not inhibit the bonding process as much, but research shows that mothers who receive epidurals show less attachment to their babies than mothers who do not. These are some examples of the effects of birth trauma on bonding. In all cases bonding is affected because it is difficult for babies to trust their parents when their parents do not accurately perceive or acknowledge their prenatal and birth traumas. In general, the greater the number and severity of unacknowledged prenatal and birth traumas, the greater the impact on bonding.

Secondly, when traumas are largely untreated, the influence on bonding is exacerbated because the traumatized infant remains in a defensive stance with respect to the world, and does not "let the world touch him." Many parents report to me that their babies are very independent, but this is often a cover for defensiveness. Such babies act as if they are OK and do not need comforting or support. They do not easily let themselves be comforted and held, either pushing their parents away and/or ignoring their attempts to comfort and console them. Many times they will only let their parents comfort them after considerable resistance.

Third, it is important to realize that a lack of bonding may be sufficient, in and of itself, to create aggression and violence. This surprising fact has been brought to light by various researchers. For example, Magid and McKelvey (1988) reported that children with severe bonding difficulties do not develop a conscience, and perform asocial or antisocial acts without remorse. Felicity De Zulueta (1993) summarized research in the field of bonding and attachment, and concluded that violent aggression is the result of damaged bonding. She writes, "One of the most important outcomes of...studies on attachment behavior is the emerging link

between psychological trauma, such as loss (of a bond)...and destructive or violent behavior." She concludes that the more damage that is done to bonding, the greater the likelihood of aggression and violence during childhood and adulthood. Fourth, it is clear from the observations of clinical researchers that the probability of societal aggression and violence are increased greatly by the presence of aggression or violence during the pre- and perinatal periods of development. Prenates pick up on aggressive and violent energies, and are likely to repeat what they experience in their prenatal life space.

WHAT KINDS OF PRE- AND PERINATAL EXPERIENCES UNDERLINE AGGRESSION AND VIOLENCE?

As a way of determining the prenatal, etiological bases for violence and aggression, I posed a basic question to a number of experts in the field, among whom were R. D. Laing, Frank Lake, Barbara Valassis, Barbara Findelsen, Stan Grof, Michael Irving, and others. I asked them to report on the kinds of regressive experiences that their aggressive and violent patients had uncovered and/or reported, and that were central in the success of treatment. Among their varied responses were common threads of consensus, among which were: (1) pre- and perinatal experiences were paramount in aggression and violence; (2) childhood experiences seemed to reflect and reinforce prenatal traumatization; (3) aggression and violence were related to the severest levels of pre- and perinatal trauma; (4) consistently related to aggression and violence were themes of loss, abandonment, rejection, and aggression; and (5) certain pre- and perinatal traumas were consistently related to aggression and violence. These experiences are described below.

In reading through these experiences, it is important to remember several basic principles, references above. First of all, multiple prenatal traumas are more likely to result in violence and aggression than single traumas. Secondly, bonding deficiencies are directly related to aggression and violence. The greater the degree of bonding deficits, the greater the likelihood of violence and aggression. Third, prenatal traumas that involve loss, abandonment, or rejection are more likely to impact bonding than other traumatic themes, and are also more likely to result in the complete absence of bonding than traumas involving other themes. Finally, the direct exposure to aggression and violence during the prenatal period is highly predictive of violence and aggression during adulthood. The old adage, "Children learn what they live," is relevant here. Like children, prenates "learn what they live," and prenates subjected to aggression -and violence are likely to manifest the same in their adult lives.

CONCEPTION

When clients who have problems with aggression and violence are regressed, they frequently encounter the experience of conception. They report that they are conscious of traumatic issues outside of themselves, in their family or immediate surroundings. The most frequently mentioned traumas involved forced sex, manipulated sex, date rape, rape, substance abuse, physical abuse, dismal familial, social, or cultural conditions, and personal or cultural shame, such as when children are conceived out of wedlock. They often experience biological encounters as sperm and/or eggs which involve intense aggression, annihilation, death, power, and/or rejection. To cite an example of traumatic conception, one child was conceived out of wedlock in a small religious community where such things were disdained. Her mother experienced shame, guilt, and public ridicule before deciding to "keep her," and the child experienced the same guilt, shame, and ridicule that her mother did. The public ridicule was experienced as particularly annihilating and hostile. This led to character patterns of self-righteousness, self-ridicule, masochism, and hostility.

IMPLANTATION

Implantation is the biological process whereby the conceptus attaches itself to the uterine wall, and is a vital and precarious stage of embryological development. Prior to and during implantation, regressed patients report that they experienced the terror of beomg near death. They report feeling unwanted and that they have no place to go, no place to belong, and 'decide' that the world is a hostile and unsafe place. They often collapse in hopelessness, retaliate in rage, fluctuate between these two extremes, and/or manifest intense rescue complexes (the need to rescue others and/or be rescued). Christ's life was, in many ways, a metaphor of implantation. There was "no room in the Inn," and He had no place that He belonged. And as the Bible declares, His life was manifested in order for Him to save and rescue mankind.

Many individuals with problems of aggression report the loss of a twin. Their problems with aggression typically have to do with masochism and/or neurotic self criticism. Embryological research indicates that loss of a twin may be much more likely than previously thought. Embryologists estimate that between 30% to 80% of conceptions are actually multiple (i.e. twins) rather than single. Since the rate of birthed twins is far less than 30% to 80% percent, embryologists conclude that many conceptions involved the death of one or more twins. This can be prior to or during implantation, although some happen after implantation.

People who experience the loss of a twin manifest several common dynamics. First of all, there is an ineffable but profound sense of loss, despair, and rage. These feelings are usually held in, but are sometimes acted out against others. Secondly, there is a chronic but unarticulated fear that loss will happen again, and pervasive insecurity. The threat of loss is defended against by distancing from others, or by engaging in codependent relationships. Third, the ability to bond with others is deficient or neurotic because there is a lack of trust in relationships, or disbelief that relationships will last. Fourth, there is often an over compliance in life, based on the unconscious feeling that "if I don't do what is expected or wanted, I will die." Over compliance feeds hostility and aggression toward others, since one cannot take care of oneself when constantly complying with others. Finally, prenatal experiences of near death and/or loss are sometimes turned against oneself or others, resulting in sadistic and masochistic behaviors, criminal violence, or sadomasochistic thinking and behavior.

DISCOVERY OF UNWANTED PREGNANCY

When aggressive clients regress to the prenatal period, they frequently and spontaneously regress to the time the pregnancy was discovered, and many of them are surprised to find that they were unwanted. The discovery of being unwanted typically leads to the realization that lifelong episodes of depression, self-destructiveness, or aggression are a direct expression of prenatal rejection. They typically report that they can trust only themselves, and that their whole lives have been geared toward denying or finding the acceptance and love that they did not receive as prenates. The percentage of aggressive clients who were unwanted at the time of discovery is quite high, and has important implications for bonding disorders. Typical responses to being unwanted are to collapse into helplessness and hopelessness, to rage at others and the world's injustice, and/or refuse to engage in life.

PRENATAL AGGRESSION

The majority of adults with problems in aggression learn that they were unwanted at the time of discovery, but many of them also learn that they were exposed to other forms of aggression during the pre- and perinatal period. Some common forms of aggression are warfare, gang fights, domestic violence, conception through rape, physical or sexual abuse of parents or siblings, annihilative energies, intrauterine toxicities, and/or abortion attempts. Prenates who experience one or more of these aggressive conditions are at risk for manifesting aggression and violence, and the greater the number of conditions, the greater the likelihood of aggression and violence.

ADOPTION

Adoption trauma refers to a broad range of painful experiences that are common to adoption. When children are adopted, they are more likely to have experienced some level of abortion trauma--there may have been direct attempts on life, abortion plans with no attempts, or abortion ideations but no plans. All of these are traumatizing to varying degrees. In addition they are likely to have experienced discovery trauma (child unwanted at the time of discovery), conception trauma (child unwanted at time of conception), or psychological toxicity (child exposed to mother's annihilative or ambivalent feelings, or to socio-cultural shame).
Adoption trauma has many different levels. The lowest level occurs when parents want their children but reluctantly give them up for adoption because external circumstances dictate. A higher level occurs when parents do not want their children and seriously consider abortion. The highest level occurs when parents are unequivocally opposed to having children, when pregnancies are resented, when abortions, are attempted, when children are put up for adoption, and when children are fostered a number of times. At high risk for aggression are children who experience the severest levels of adoption trauma.

PRE- AND PERINATAL MEDICAL PROCEDURES

When prenates experience severe forms of traumatization, as described above, they are also likely to perceive subsequent events in similar contexts. This is especially true when subsequent events are stressful life transitions (such as birth, adolescence, first jobs, new relationships, etc.), and/or when subsequent events are symbolically similar to traumatizing events. For example, if prenates experience prenatal violence, then they are likely to experience life transitions (such as birth) in violent ways. Freud called this process recapitulation. Among other definitions, recapitulation means that prenatal experiences shape how subsequent life experiences are perceived.
The following case is an example of a mother who had only limited prenatal traumas, but which nevertheless influenced her baby's perceptions and experiences of the birthing process. The mother was 28 years old, and had never attempted to conceive a child. Her own mother had had difficulty conceiving children, so she was anxious about her ability to conceive. She wanted to have a child, and in spite of being unmarried, conceived a child with her boyfriend, who was also ambivalent. They conceived after much effort, whereupon the boyfriend turned brutal and violent against the mother and her baby (it was later discovered that the boyfiiend's father had been abusive to him during the prenatal period). A series of beatings occurred, after which the mother fled. She spent the remainder of her pregnancy in a distant and safe place, under conditions that were close to "ideal." She was attentive to herself, her body, and to her baby. She meditated daily and earned income from work she did at home. She had an extensive and supportive family system as well as friends, and the remainder of the pregnancy was uneventful in terms of other stresses and traumas.
She devoted time to her unborn baby every day, talking and singing to him, and doing bonding exercises. She gave birth at home, and described the birth as short and simple, with no complications. In spite of having a largely positive pregnancy and an easy birth, the early abusive experiences haunted her and her baby. In particular, her baby experienced the birth as very traumatic. (This is not an unusual event, even when mothers describe births as simple and uneventful). This was evident in childhood memories of his third trimester and birth. He experienced his mother's jogging during the third trimester as abusive, saying that his head bounced painfully on his mother's pelvic bones. He experienced the perineal massages (given repeatedly during birth) as intrusive, and the contractions as abusive and violent. He was aware of his mother's physical pain, felt the birth was hurting her, and felt guilty that he could not protect her. In short, all of his birth feelings appeared to be overlays and manifestations of his unresolved abuse traumas from the first trimester. It is important to realize that, even more so than children or adults, prenates perceive and interpret life experiences in terms of past experiences. This is so because prenates do not have sufficient neurological integrity or adequate life experiences to assist in discriminating between current and historical realities.
When prenates experience abandonment, rejection, violence, or abuse, as has been described in this paper, they routinely bring these experiences to bear during the birthing process. Amniocentesis needles and chorionic villae catheters are commonly perceived as aggressive, annihilating, and/or rejecting instruments. Anesthetic procedures are often perceived as attempts to disempower or to poison (a reflection of abortion trauma). Augmentations (inductions and "breaking waters") are usually experienced as boundary violations. Forceps and vacuum extractions are often perceived as attempts to control or annihilate. Contractions are often perceived as attempts to annihilate, destroy, or impede. For example, one adult who had been exposed to chemical and mechanical abortion attempts (his mother had taken low-dose cyanide pills and repeatedly pummeled her abdomen and uterus) experienced contractions as attempts to beat him to death, and experienced anesthesia administrations as attempts to poison him.
It is vital that medical and obstetrical personnel understand the importance and relevance of pre- and perinatal traumas, and understand that babies are likely to experience the birthing process in terms of prior traumatizations. This means that birth can be very traumatic, simply on the basis of personal history. If this fact were known, then medical interventions could be limited to situations where they were absolutely necessary, or medical interventions could be humanized in a variety of ways. Some useful procedures might be asking the permission of babies to implement procedures and getting responses through the mother's intuition, letting babies know that they might experience pains and discomforts, and empathizing in terms of prior traumas, letting babies know that birth is a difficult transition with the potential for negative and overwhelming feelings and acknowledging babies post-birth emotions as legitimate expressions of a difficult birthing process"all this could help to minimize potential trauma. It is also important to acknowledge the positive aspects of birthing, the wonder and joy that belongs to the birthing process. Few births are

entirely difficult, and few are completely free from trauma or pain. We need to acknowledge the whole gamut of human experiences as they unfold during the birthing process.

TREATMENT

It is important that pre- and perinatal traumas be treated as early as possible. This is so because, as previously discussed, early traumas shape how subsequent events will be perceived and experienced. If treatment occurs early on, during gestation or the first year, then childhood experiences can be freed from prenatal influences, and children can live their lives unencumbered by the bonds of trauma. The effects of trauma have been described elsewhere (Emerson, 1992, 1994). Unresolved traumas affect the spiritual and psychological development of children. In contrast, children who had no trauma, or whose traumas have been resolved, are clearly unique in the following ways. They are more spiritually evolved, manifest higher levels of human potential, and are developmentally precocious. They exhibit higher self-esteem and intelligence test scores, and they are more empathic, emotionally mature, cooperative, creative, affectionate, loving, focused, and self-aware than untreated and traumatized children (Emerson, 1993).

The fact that pre- and perinatal traumas shape how subsequent life events are experienced does not mean that childhood experiences, in and of themselves, are unimportant in terms of human development. On the contrary, childhood experiences are very important in determining and shaping who children will become. It is precisely because childhood experiences are so important that it is vital to free childhood from the bonds of pre- and perinatal trauma. If these traumas can be resolved before childhood, then childhood has the opportunity to be experienced on its own, without traumatic influence from the prenatal period, and without the defensive forces that inhibit feelings of safety, security, and growth. Furthermore, children can be freed to exhibit and manifest their own unique human potential, to utilize their own inherent levels of intelligence, and to, become themselves, unencumbered by prior traumas.

In addition to these benefits, society can be freed from the increasing burden of aggression and violence. According to statistics reported at the 1995 APPPAH Congress, violence and aggression are on the rise, and are reaching epidemic proportions. Therapists who specialize in anger resolution report that about one client in five carries a significant degree of anger and rage. Aggression and violence are on the rise, and are extremely costly in terms of human lives, in terms of financial and budgetary considerations (prisons, jails, and law enforcement are very costly, and deprive our school systems of needed finances), and in terms of the safe and efficient functioning of our institutions. These violent feelings are directed toward self and others, and are very difficult to resolve for the following reasons. First of all, most therapists do not realize that anger and rage, at their deepest levels, are caused by pre- and perinatal traumas, and are related to perinatal bonding deficits.

Secondly, most clinicians fail to realize that anger and rage cannot be resolved solely by talking therapies. Instead, anger and rage require physical and emotional release. Third, anger and rage are inextricably intertwined with low self-esteem, shame, guilt, disempowerment, and forgiveness. These concepts need to be understood and recognized in the treatment of aggressive disorders. Finally, the ultimate resolution of rage and anger requires that relevant pre- and perinatal traumas be uncovered, encountered, catharted, repatterned, and integrated into consciousness. Additional aspects of treatment should include opportunities for re-bonding, i.e., for bonding in ways that were impossible at the time of traumatization, or bonding in ways that were inhibited by unresolved traumas. The Association for Pre- and Perinatal Psychology and Health, the International Primal Association, The Star Foundation, and Emerson Training Seminars have personnel and lists of professionals who do such work.

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Editor's Note: Readers may be interested in an earlier article by Dr. Emerson, "Psychotherapy with Infants and Children" published in the Pre- & Perinatal Psychology Journal Vol 3(3), Spring 1989. This article includes drawings made by children in the course of treatment. The author invites email addressed to starvapor@aol.com.

POINTS OF VIEW

The Mind-Body Spirit Connection:
Ancient and Modern Healing Strategies for a Traumatic Birth and the Sick Newborn

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Let us talk of healing. The ancient wisdoms teach that all worlds exist now--the past, the present, and the future--all co-existing simultaneously. Man invents nothing. He merely discovers, interprets, and reports what already exists in nature. Many medical doctors believe that it is really nature that heals, not the doctor or the drug, and that medicine merely assists the patients to heal themselves.

The traditions of both wisdom healing and physical medicine can trace their origins back 2600 years to the third Egyptian dynasty of King Zoser, and that master healer-physician, Imhotep. Throughout the flow of human civilization, in Greece, China, Persia, Africa, and India, wisdom healing and physical medicine were not separated. True healing treated man as a whole, as spirit, mind, and body. This concept is epitomized in the 3,000 year old Oriental system of Ayurvedic medicine, which not only incorporates over 2000 medicinal herbs and minerals, but also includes surgery, psychoanalysis, and the cleaning of man's subtle energy-body.1

The great healer-physicians of history, including Hippocrates, Avicenna, Paracelsus, and Galen, all recognized that man is far more than a mere physical body and that any attempt to truly heal by treating the body alone is partial and incomplete. Paracelsus, as a healer-physican, overshadowed his medical contemporaries and set the standard for European medicine for many centu ries. He is credited with having founded the sympathetic system of medicine, wherein everything which occupies space-all bodies, plants, minerals, heavenly bodies--influence man by means of subtle ener gies. He stated that "the ultimate cause of illness is a weakness of the spirit" and he advised his fellow physicians to search within themselves for spiritual insight to heal their patients. Hippocrates also held to the practice of healing the spiritual as well as the physical parts of his patient's illness.

The birthplace of Hippocrates, the island of Coz, was reputed to have special healing powers, a curative vibration, inherent in the earth and in the surrounding atmosphere.

A word must be said about Shamanism. Dr. Michael Harner states that Shamanism represents the most widespread and ancient system of mind-body healing known to humanity. He states that the methods are at least 20,000 or 30,000 years old. The Shaman is able "to transcend the human condition and pass freely back and forth through the different cosmological planes." Shamanism flourished in the ancient cultures that lacked the technology of modern medicine.2

Now on the eve of this twenty-first Century, we stand upon the shoulder of centuries of ancient healing tradition, peering still further into the bio-psychic evolution of our species. What possibilities do holistic health and consciousness research hold for our expanded awareness as healers?

Some of the most influential present day research has been done by Dr. Victor Beasley and Dr. Christopher Hill in connection with Chakra functions, energy vibrations, and healing. Basically, they found that "human consciousness is a product of light and that an in dividual's perception of the world is determined by how cosmic light, breaking up the stars' and the sun's undifferentiated white light into the seven color spectrum of the rainbow. Thus light, or cosmic energy, becomes both the creator and the conditioner of the human consciousness and health. The situation is somewhat analogous to holographic laser technology wherein coherent light from a single source is divided into two separate beams, passed and refracted through certain filters, and eventually recombined as a standing wave form which creates an image we call a hologram. Human consciousness then is a hologram created by cosmic light-energy." Hence, all energy from light, sound, color, and all substance becomes increasingly important to the well-being of the individual and has relevance for modern day healing strategies.3

Our hospitals, like our prisons, are made of concrete and steel, are for the most part void of natural light, color, and sound, and contain little, if any, negative-ion charged air. Individuals placed in solitary confinement suffer severe disturbances in consciousness, and we create a similar kind of deprivating environment when we place our babies in Neonatal Intensive Care.

Both ancient and modern medicine are well aware that sudden, intense, or prolonged stress is known to predispose one to disease and to cause a breakdown in the physical cells and in tissues.

Stress tightens the body, blocks the chakras, and interferes with the free flow of energy, both from within and from without. It is well known in the present day Eastern and Western medicine that relaxation is a primary requisite for healing and is a major component of any healing strategy. This premise was also accepted in ancient healing. Relaxation for healing was induced in ancient Africa by placing the patient in a circle of drummers. The monotonous, continuous drumming brought relaxation and subsequently an altered state of consciousness. In Egypt, China, and India, drums, chants, music, bells, water, movement, and meditation was used to create deep states of relaxation so that healing could take place. A few hospitals today have innovative provisions for reducing stress in the adult and older child, yet virtually no hospital has considered stress reduction for the NICU. Unfortunately, much of the stress reduction being done in modern medicine has to do with drug therapy-relaxants and tranquilizer-chemicals which act on the nervous system as depressants.

If our earliest beginning is in a stress-free womb, life is easy and progressive. If, however, the mother smokes, drinks, has poor nutrition, or has a great deal of anxiety and unhappiness, the intrauterine environment is not a healthy one, and the fetus and consequently birth is adversely affected. Drs. Thomas Verny,4 Stanislav Grof,5 and others have awakened us to the developing consciousness of the fetus, of the energy vibrations being transmitted not only through the maternal system, but also from the external environment.

Let us consider birth. The process has moved from natural, primitive environments to modern, technological settings of sterile stainless steel. We are connected to machines that interfere with the natural progression of birth. We use machines to make diagnoses that we don't trust our wisdom to make. A particular care is the routine use of the fetal monitor, which many feel has contributed to our high rate of cesareans due to inaccurate reading of the infant's condition. We justify the whole sale use of sedatives, artifical hormones to stimulate labor, amniotomy, epidurals and other anesthesia, episiotomies, forceps, and the controversial anmiocentesis and ultrasound procedures. Much of this medical intervention becomes iatrogenic and toxifies both mother and infant. In this strange, technological, and unnatural setting, both mother and in fant become stressed.

In the earliest stages after birth, the infant is in a state of consciousness that is all sensation. He has no capability for thought or reason, reflection, or judgment. He is more vulnerable to his experience than an adult, for he has no precedent, no frame or reference with which to qualify or to understand his impressions and sensations.

In the womb, the infant had all his expectations fulfilled. Nothing has prepared him to be alone and even less, left alone to cry. Nothing has prepared him for a pin. He becomes confused, his crying--the only language he knows--doesn't bring relief. His sense of rightness or essential goodness about his universe and the people in it becomes distorted. He becomes distrustful, confused, and frightened away from his mother's body. He is in a state of stress and pain.

Jean Liedloff in The Continuum Concept,6 writes "the infant (like the Guru) lives in the eternal now. The infant in arms (like the Guru) lives in a state of bliss. The infant out of arms is in a state of longing in the bleakness of an empty universe."

As our technology increases and the biological survival of the child becomes paramount, the possibilities for stress increase. Even to the most sophisticated observer, a walk through an NICU reveals an environment of space-age technology of chemical and medical interventions.

The injections, gavage, blood taking, insertions of catheters and needles, and the use of ventilators are clearly stressful at best and create torturous emotional conditions for the infant. We see infants with scarred and deformed heels from repeated heel sticks, with deformed and sometimes irreparable damage to the palate and upper lip from feed ing tubes, many left in long past the time when the infant could nurse from a nipple. Surely the most frightening and agonizing procedure for the sick infant is the injection of curare to paralyze them for the use of a new space-age jet ventilator.

Stress and anxiety increases the MAO levels, and the entire immune system is disturbed. Many chemical and mechanical treatments are continued long after their value as diagnostic or life-saving agents have passed. The complications that almost routinely develop are often more insidious than the original condition. If these conditions existed anywhere but in a hospital, we would be charged with child abuse. And abuse it is--of the cruelest and most frustrating kind. We save lives, but in the process, we frequently are damaging the quality of the emotional and spiritual essence of the infant. The effect of this trauma can last a lifetime.

One of the most frequent iatrogenic conditions we see is in newborn jaundice. Although phototherapy with bilirubin lights has been used for more than 20 years, it is still not clear which babies should be put under the lights, for how long, what wattage the lights should be, how effective the process is, and how extensive the side effects are, especially long term effects. Speck stated that phototherapy "may alter the DNA of human cells and may be a carcinogenic hazard." The infant is often separated 23 out of the 24 hours from his mother, sometimes for a week or two. The lights, which are blue and white fluorescent, also have been known to affect the nursing staff with discomfort and vertigo.

The atmosphere in the NICU is charged with positive ions. Energy from natural sources for babies and nurses is blocked. The burnout rate among personnel is higher than in any other unit of the hospital.

Hippocrates said, "first let us do no harm." The best intentioned physicians sometimes prescribe drugs or treatments which do more harm to toxify their patient's system than to correct the cause of the illness. This is not always the doctor's fault, who may be acting properly and practicing state of the art medicine. The problem lies more with conventional drug and treatment therapy as an incomplete approach to healing.

In every NICU we see infants lying passively. Many do not cry. Those who do, have weak, little wails of protest that for the most part go unanswered.

The "inhibition of action" behavior was first discussed in 1952 to describe the submissive behavioral pattern, a pathogenic state, that re sults when the organism can not respond to stress and does not generate noradrenaline and cortisol in the body.7

Noradrenaline sets the system in action for fight or flight. The hypothalamus is activated and kept in an overload condition. Cortisol triggers the inhibition of action and depresses the immune system and so a vicious cycle is set in motion. When this kind of "lockjaw" condi tion exists even for a short time, we begin to see damage. The inhibition of action syndrome produces apnea, cardiovascular, gastrointestinal, and upper respiratory damage. It produces emotional damage in supressed energy, lack of trust, and an inability to form attachments and bonds. The infant becomes tactile defensive, pathologically passive, with rigid musculature or lack of muscle tone. Thought processes become abberant because of pain and a sense of futility and abandonment.

Dr. Walter Hess produced the changes associated with the fight/flight response by stimulating an area within the hypothalamus of a cat. By stimulating another area of the hypothalamus, another response was produced whose physiologic changes were similar to those produced during the process of meditation or deep relaxation. This response is similiar to an altered state of consciousness or an alpha wave state. Hess termed this reaction "the trophotrophic response" and described it as a protec tive mechanism against overstress, which promotes healing processes. Endorphines are produced and a sense of well being occurs.8

There is a spate of modern day research which shows that patients who receive relaxation techniques have lower levels of adrenaline, lower and more stable blood pressures, and slower and more regular heart rates. Research with premature infants shows there is a greater output of somatotrophin growth hormone, indicating increased myelination, when tactile and vestibular stimulation is provided them soon after birth.9

Bovard found reduced pituitary-adrenal and sympathetic-adrenal responses and found that anabolic process were stimulated when gentle touch was provided.10

Weinberg's classic study found there was less output of cortisosterone when the organism was under stress if there had been gentle stroking and touching prior to the onset of stress.11

Ancient healing wisdoms and shamans knew of this protective healing mechanism and attempted to elicit the responses in their patients. The healing response can be produced in the organism through deep relaxation or meditative states with measures such as rhythmic movement, gentle stroking, massage, affectionate touch, muted monotonous sounds, certain music, colors, and water, aided with negative-ion charged air. Ancient healing was frequently conducted in the out-of-doors, in mild, warm sunlight or near the ocean.

To elicit relaxation and healing responses, mothers in Pithiviers, France, Caracas, Venezuela, and a few other places in the world, are being given the freedom to move about during their labor to assume any position they choose, and to have the people to whom they feel emotionally close with them. In these birthing centers medical intervention is kept to a prudent minimum and great attention is given to reducing stress. Music of the mother's choice can be played. Soft, muted colors surround her in her visual environment. The energy from the color is assimilated and is used to alleviate pain. Growing green plants are placed in the room to provide plant energy. Natural lighting should be used. Artificial lighting should be dimmed or candles used. Some women may like the smell of incense burning. The mother is given nourishing food or drink to sustain her physical energy. She is surrounded by other tender and caring women to comfort and assist her to give birth in a natural, safe, and facilitating position. Top priority is given to the quality of the physical, mental and emotional setting. Mothers are encouraged to be open and receptive to their natural and instinctive impulses. They are free to cry, to scream, or to make any noises or sounds that comfort them or express their feelings. When we close off our sounds, we tighten muscles and obstruct feelings. If a mother chooses, she can give birth in a tub of warm water.

In these places, medical technology is applied only when needed. There is no interference in the normal sequence of labor, birth, and the post-birth period. The unit of mother, father, and infant is kept intact. Above all, the attendants permitted at this miraculous

event must be sensitive, calm, confident, and loving. They must also be without ego and lend their positive, healing energies to the birth process. Much has been written about the healing power of a loving caregiver. As a baby emerges, the mother responds instinctively and puts the baby to breast. It also seems instinctive for her to want to return her baby to moisture, to water. A tub of warm water is provided for her to immerse the baby.

A mother's healing, and that of the baby, is largely dependent on their symbiotic relationship, expecially if birth is traumatic. Mother and baby must remain together for physiological as well as psychological healing and nurturance. Dr. Marshall Klaus has stated that the sensory interaction of mother and infant, the transfer of energies from one to the other produces hormones and enzymes that promote healing homeostasis in both.12

Touch is vital to the newborn. Throughout history, mothers have known that the survival of the species depended on their close physical contact with their baby. Research indicates that the infant is more responsive to touch within the first 5 days than to any other form of stimulation. Other tactile healing measures such as laying the baby on a lamb's wool skin can be used; those from New Zealand have been researched and seem to have special healing properties.l3 Only natu ral, soft fibers should be used next to the infant's skin. Frequent immersion in warm gentle moving water is very healing. The benefits of water therapy are multiple and many infants in NICU could be placed in small tubs of water for relaxation.

Visual healing strategies can be used by presenting colors on cards or swatches of cloth with all the rainbow colors. It is known that the cones, the light receptor cells in the eye that give color vision, are not well enough developed in the newborn to see color, so bright reds, blues, purples, and greens could be used for energy vibrations. Hanging crystals for sun-ray energy vibrations would also be stimulating.

Auditory healing strategies such as monotonous, rhythmic sounds are very helpful. Cassette tapes can be played to the infant that provide many different kinds of healing energies. Sounds of the ocean or soft drum beats such as the kind Dr. Michael Harner recorded can provide deep relaxing states.14 A chanting tape produced by Brother Charles has been found to be very relaxing and almost hypnotic. The intrauterine sounds have been researched in many nurseries and have been found to create soothing, comforting effects in newborns. Music of Bach, Kitaro, Halpern, Georgia Kelly, and many other composers provide healing through auditory senses.

Vestibular healing measures can be provided by the use of cradles, hammocks, rocking, and other forms of gentle and rhythmic movement.

Our effort here is to create a healing sensory environment which will relax and sooth the infant so that emotional and physical healing can take place. The healing energies described here are designed to open the healing channels in the infant and to provide healing energy vibra tions to counteract the detrimental influences of the NICU. This kind of a sensory stimulation is not to be confused with the mental and motor stimulation which is used in many newborn and intensive care nurseries today, and is designed to activate and stimulate the infant's physical development. The kind of healing strategies described here are to provide deep relaxation, to elicit the trophotrophic response, and to promote healing on all levels for the infant.

In 1979, Dr. Victor Beasley wrote that "healing is no longer something that occurs exclusively in man's physical body, as determined by the presence or absence of clinically detectable symptoms, pain, or other somatic disease. Healing attempts to tune the entire being into a harmonious whole. This is something we and ancient medicine have long known in theory. Now we are challenged to give practical manifestation to this knowledge. Healing in its essence is a spiritual-soul impulse operating in the worlds of matter, for in the ultimate sense, the patient, not the physician, heals himself through contact with the higher forces of his own cosmic-governed consciousness, whether or not he is aware that such contact has been made. This is Nature's reality."16

We must strip away culteral mislearnings in order to discover our instinctual selves, to discover creative, spontaneous rhythms of healing that have abounded in our Universe since the beginning of time, to trust our innate wisdom, to trust our body's signals, to trust the prudent use of technology and pharmacology, knowing that in its extravagant use, we can go astray and create harm. We must learn to be patient with the body's healing time schedule, to believe intently that we, as caregivers, have unlimited and untapped healing power to transmit through natural and simple ways to the mother and her infant to enable them to mobilize their own healing energies.

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