Healing Through the Remembrance of the Pre- and Perinatal: A Phenomenological Investigation

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Abstract

This existential-phenomenological study focused on the experience of healing through pre- and perinatal recall. Interviews were conducted with 7 adults attesting to having healed conditions of: syncope, phobias, arthritis, asthma, migraines, depression, suicidality, obsessive-compulsion, side pain, and dysfunctional interpersonal patterns. The co-researchers, 3 men and 4 women, were Caucasian Westerners, educated to the Associate of Arts level and above, with a mean age of 44. Intentions were to: (a) illuminate the experience, (b) examine the healing benefits, and (c) underscore the impact of obstetric intervention. Reviewed literature depicted: transcendent, fetal, cellular, and somatic memory/consciousness within a holonomic paradigm; current repression and false memory debates; hypnosis, holotropic breathwork, psychedelic and primal therapies, and somatotropic therapy with infants and children. Hycner's (1982) 15-step analysis of interview data revealed 7 individual, 2 unique, and 2 general themes. The general themes, A Range of Intensely Felt, Mostly Negative, Emotional, Physical, or Feeling States, and Transpersonal Experience, capture the structural underpinnings of the phenomenon. All co-researchers related pre- or perinatal trauma, and subsequent child abuse. While unprecedented in the literature, this continuity of negative circumstances and feeling states may reflect Grof's (1985) "systems of condensed experience" (COEX). The COEX is a subset of the organizing principles used by Grof to map the human unconscious. Here, like circumstances, emotional quality, and physical sensations occur in the biographical, perinatal, and possibly the transpersonal levels. Three co-researchers related remembering deleterious effects from obstetric intervention: long-term depression and slowed labor from anesthesia, pain from forceps, and vertigo from inversion at birth.

Follow-up questionnaires indicated enhanced quality of life for all participants. Results imply fetal/neonatal consciousness, and the need for research into the long- and short term effects of obstetric procedures. Full resolution of some physical and psychosomatic conditions may necessitate intervention at the pre- or perinatal levels.

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Loving appreciation is due my mother, Mary Basden, for her devotion to me and her willingness to look at herself. Without her consistent emotional support and financial assistance, the writing of this study might not have been possible. Furthermore, enormous gratitude is due her and my daughter, Carissa Barker, for sharing the deepest possible understanding of the nature of birth.

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This dissertation is dedicated to people everywhere that suffer from chronic immune dysfunction in its many manifestations, and to those helping to heal them. We are the metaphorical canaries of this coal mine.

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CHAPTER 1

Birth affects us in ways we can't begin to imagine,
until we take the courageous step into looking backwards to our
beginnings...and then birth and the trauma that is
created for us loses the control it has on our life.
If we'll face it, have the courage to face it.

Caroline

This study is an exploration of healing resulting from the remembrance of the pre- and perinatal period of life. Data have been collected from interviews with 7 participants who claim to have remembered some aspect(s) of the pre- and perinatal realm of their lives, and as a result of this remembering experience, attest to an alleviation or full cure of physical or psychospiritual condition(s).

As a psychotherapist, I have the honor of watching my clients grow. While they share their self-exploration, the layers of sorrow and pain become seeds that render transformation. This is one of the treasures of my work. Still, it seems that most of my clients reach a plateau of personal growth without a complete resolution of the symptoms that prompted them to seek treatment in the first place. Most choose to settle for this. After becoming stuck at such a plateau in my own healing, I searched for access to the deeper realms of my mind. I wanted to heal all the way through and to guide others in healing as deeply as they cared to go, as well. I found my birth.

During a session focused on age regression, I found myself in the throes of labor. I had been through labor while giving birth to my daughter 25 years before; but this labor was different. In this labor, I was the one upon whom contractions pushed, the one being forced relentlessly out of a very constricted space. Since that day, I have continued to regress to my birth, before it, and after it, while pursuing my healing quest. To say that the journey has been thrilling, frightening, painful, joyful, and deeply fulfilling would not adequately convey the experience. Therefore, I have created this study, a phenomenological exploration of healing through the remembrance of the pre- and perinatal.

The field of pre-and perinatal psychology consists of a knowledge base drawn from such diverse disciplines as philosophy, physics, psychology, psychiatry, pediatrics, midwifery, obstetrics, nursing, and law. It is a new, rapidly growing area of study, the main tenets of which are (a) to illuminate the nature of consciousness of the unborn and the newborn, (b) to examine the long- and short-term effects of pre- and perinatal experience, (c) to expand the concepts and practice of psychotherapy in order to alleviate psychospiritual, and physical damage inflicted at the pre- and perinatal level, and (d) to educate the public and professional communities in order to develop methods of treatment designed to alleviate human suffering and improve the quality of our lives.

Until recently, intrauterine life and actual birth experience have been understood only through conjecture. Some theorists felt the womb to be a paradise, with baby's needs being met effortlessly (Rank, 1924). Modern perinatologists are suggesting that the fetus absorbs its mother's thoughts, feelings, joys, and traumas (Raymond, 1987; Vlcek, 1989), not to mention chemical pollution from cigarettes, alcohol, et cetera. Studies conducted in the last two decades point to the fetus's ability to learn and interact, an ability far surpassing previous expectations (Sallenbach, 1994).

A study demonstrating the consciousness and sociability of twin fetuses was conducted by Alessandra Piontelli (1992). Four sets of twins were observed by ultrasound, periodically over the course of the pregnancies. Follow-up observation was conducted through age 4. One of the most striking features for Piontelli was seeing that behavior after birth was on a continuum with what had been happening before birth.

Loving, fighting, and dependency behaviors between the twins were seen through the ultrasound lens as they kissed and hugged, or punched and kicked each other repeatedly. Each pair seemed to manifest a certain theme with their behavior: one set was loving, another contentious, and yet another was passive.

The loving pair consisted of a boy who was active, attentive, and affectionate and a girl who would follow his lead. The male of the pair appeared to feel claustrophobic as he kicked and wrestled with the

placenta, constantly pushing for space and looking disgruntled. He was, however, seen reaching out to his sister through the membrane that separated them, caressing her cheek or rubbing her feet with his. The female twin reciprocated in kind. The following are excerpts from ultrasonographic observations of this pair of twins. Piontelli (1992) observes at the 20th week,

> The little boy (Luca) seemed much more active than the girl. He kept turning and kicking and changing position and stretching his legs against the uterine wall....As his mother remarked, "Oh, my God!...look at him...he is so small and he already seems fed up with being in there..." He conveyed the same impression to me, and I wrote in my notes, "Watching him is more like watching a few months old baby or even a little adult...one almost forgets he is a fetus...he seems to have a strong and interesting personality..."
>
> From time to time Luca would interrupt his motor activities and seemed to turn his attention towards his sister. He reached out with his hands and through the dividing membrane he touched her face gently, and when she responded by turning her face towards him, he engaged with her for a while in a gentle, stroking, cheek-to-cheek motion.
>
> Then at the 20th week one of the physicians noted, "Look what the boy is doing!...he keeps banging his head against the cervix...he wants to get out!...he is rather independent this one!...his sister is much more quiet...he is also doing something with his legs...sort of touching his sister with them...rubbing his feet against hers...he is not kicking her though...they always seem to like stroking each other..." (p. 123)

Postnatal notes on this twin pair found them just as affectionate as they were prior to their birth. At 1 year of age, they could be seen playing with each other, a curtain between them as if a dividing membrane, touching, hugging, and kissing. The little boy of the pair was as self-starting, independent, and intolerant of limitations as he was known to be before birth.

The other twin pairs manifested the same types of behaviors postnatally, as they had prenatally, often acting as if they were still vying for space. One mother commented to Piontelli as her twins attempted

to pass through the door at the same time, “They always have to collide to get in...as if there was no space for two...” (Piontelli, 1992, p. 123).

As a result of these studies and a quantity of mounting evidence, pre- and perinatal psychologists are calling for a new paradigm where the intelligence and sensitivities of the unborn and the newborn are concerned. They are proposing that human memory and consciousness extend back farther than young childhood. Recognizing this, they suggest that the examination of early memory and consciousness can contribute much in the way of healing psychological and physical impairment, and to the design of a new and more humane treatment of neonates.

This study intends to illuminate the experience of the remembrance of the pre- and perinatal realm. It provides the reader with a “subjective snapshot” of the experience. Although anecdotal evidence and documented studies are replete in the literature as to the healing potential and results of psychotherapy involving the reexperience of birth (Castellino, 1995; Emerson, 1978, 1987; Grof, 1975, 1979, 1988; Grof and Grof, 1980; Janov, 1970, 1983, 1991), the current study was not designed to demonstrate a causal link between birth and psychological or physical dysfunction. Rather, my expectation was that healing, as it occurs in the remembrance of the pre- and perinatal would become clear within the contents of the interviews. In Chapter 4, Results and Discussion, I have isolated portions of the interviews which illuminate the healing aspects of the experience. Further, since all of the participants espouse the healing nature of this experience, there are no contradictory opinions or results. However, in Chapter 2, Literature Review, I endeavored to give a voice to varying viewpoints regarding the phenomenon of pre- and perinatal memory.

I recruited co-researchers who attested to having had profound, life-changing experiences that they attribute to the remembrance of the perinatal. These pivotal changes have been psychospiritual or physical in nature. The co-researchers used age regression, hypnosis, primal therapy, and relaxed focused attention to evoke a pre- and perinatal remembrance. One used no formal technique at all.

Preliminarily, I invited the participants to share

their experience via written questionnaire. The question that was asked was, What is the experience of the remembrance of the pre- and perinatal realm of life? As a result, seven qualified people responded to the advertisement (see Appendix G). Only 3 of the 7 complied with the request to send a written protocol of their experience. They were willing, however, to participate in oral interviews. As a result, I discarded the written protocols and conducted interviews with all of the co-researchers, recording them on tape. Concurrently, I became aware that since the focus of the study was not solely the remembrance of the perinatal but also the experience of healing, the question became, What is the experience of healing through the remembrance of the pre- and perinatal?

Follow-up interviews were conducted, designed to clarify and encourage a full description of the occurrence. Using the transcribed interviews as stimulus/reminders, I read them slowly back to the participants, allowing them to respond to their own information on tape. The second interview was transcribed and blended with the first (Appendix I). At that point, a follow-up question was asked of the co-researchers, What was healing about this experience for you? Answers to the follow-up question are found in Appendix K.

A phenomenological method lent itself to my study since it is the experience of healing through remembering the pre- and perinatal realm that I wished to impart to the reader. The literature review speaks to the theories involved. It addresses history, a new paradigm, memory and consciousness, pathology, healing, long-term effects, technology, and psychotherapeutic method. However, in terms of research, phenomenology has permitted me to record as closely as possible, the subjective experience of the pre- and perinatal.

Significance of the Study

Every being has a birth; every endeavor a beginning. Birth is an apt metaphor for the lengthy and arduous struggles of life. Themes of birth thread through literature, art, religions, mythology, astrology, philosophy, psychology, medicine, science, and history. Birth of one sort or another is a compelling drama to which humankind is repeatedly drawn, birthing ourselves and others through relationship, marriage,

rites of passage, youth, personal growth, middle-age, old-age, and death.

DeMause (1981), a psychohistorian, believes the birth experience to be so intrinsic to human existence that the unresolved roots of it remain active in the unconscious for the whole of life. He suggests that the repetition compulsion of the psyche, apparently seeking resolution, reenacts the birth trauma within the context of any group experience. According to deMause, so compelling is this unresolved trauma that people come together in groups with the subconscious motive of regressing to the perinatal level of unconsciousness. Acting out the experience en masse, they create political movements like war and revolution.

What, then, is to be gained by conducting a study focused on birth? What could be the significance of remembering one's beginnings? Is working toward reexperiencing birth healing in some way? Will it tell us something we do not already know? Will we be able to use the information gained to change or improve anything? These are essential questions, the answers to which this study will not entirely supply. Rather, my hope has been to promote an investigation aimed at raising conscious awareness of the issues involved.

Many of these issues revolve around modern obstetric procedures. The safety of routine interventions such as ultrasound, amniocentesis, chorion villae testing, fetal heart monitoring, non-emergency cesarean section, forceps and vacuum assisted births, all types of anesthesia used during labor, the inverting of newborns at birth, the separation of mothers and newborns at birth, early umbilical cord severance, and circumcision have been called into question as having serious and even fatal consequences (Arms, 1975, 1994; Bowlby, 1961; Chamberlain, 1994; Emerson, 1998; Feher, 1980, 1989; Friedman & Neff, 1987; Mitford, 1992; Montagu, 1964; Noble, 1993; Pearce, 1992; Verny, 1992; Verny & Kelly, 1982.)

The notion that newborns cannot feel pain has been maintained by medical science in spite of numerous studies to the contrary and the dictates of common sense and decency (Chamberlain, 1991, 1994; Marshall, Porter, Moore, Anderson, & Boxerman, 1982; Pearce, 1992). Chamberlain (1994) reviews this issue vividly in, "Babies Don't Feel Pain: A Century of Denial in

Medicine." Circumcision, for example, often conducted under the pretense that infants don't feel pain, is considered by many to be a cruel, abusive, and completely unnecessary procedure, a procedure that can cause dire short or long-term consequences for men and boys (Arms, 1994; Bigelow, 1995; Chamberlain, 1991, 1994; Noble, 1993; Pearce, 1992).

I began my study with the hopes of (a) of exploring the experience of healing that may be inherent in regression to the pre- and perinatal, (b) examining the resulting benefits and drawbacks, and (c) raising awareness of the long- and short-term outcomes of routine obstetrics. I invite the reader to explore the current investigation, for I believe that to a large extent these goals have been realized.

CHAPTER 2

Literature Review

Clinicians, on the other hand, may assume that cognition awaits birth before getting under way. There is no good biological reason for this assumption: Indeed, there is good evidence to support the view that in utero the fetus is already using its CNS to psychobiologically "know" its environment.

John A. Connolly and John H. Cullen (1983, p. 280)

...if you look in the index of recent textbooks on psychology, you are not likely to find "consciousness," "mind," or even "emotions." These subjects are basically not in the realm of traditional, experimental psychology...

Candace Pert (1986, p. 9)

Introduction

Literature pertaining to the remembrance of the pre- and perinatal level of development could be called esoteric. It was unheard of before Albert de Rochas recorded his clinical hypnosis experiments of the 1890s (Chamberlain, 1988, p. 208). The concept of remembering birth and before is equally unknown and has never been researched by mainstream elements of the natural or psychological sciences. Further, perinatal psychology generally is studied only in transpersonally oriented universities. The subject has been embraced by a small portion of the psychoanalytic community and a few perinatal psychology groups in the USA and Europe. The bulk of the writing about perinatal psychology can be found in journals such as the Journal of Prenatal & Perinatal Psychology & Health, The International Journal of Prenatal & Perinatal Psychology & Medicine (found in Germany or in the National Library of Medicine in the USA), the Journal of Primal Therapy, Aesthema (The International Primal Association), and Primal Renaissance: The Journal of Primal Psychology.

Perhaps because babies cannot talk pre- and perinatal remembrance is difficult to prove. Anecdotal evidence

of the phenomenon is easy to come by, but controlled studies are not. Therefore, testimony to its veracity is dismissed by the scientific and psychological communities in favor of the also unproved but long-trusted theory of "infantile amnesia." The concept that a state of complete amnesia is normal in all persons before the age of three or four is based on the idea that most adults and older children do not usually have memories for events occurring before that age (Eisenberg, 1985; Howe & Courage, 1993; Loftus, 1993; Pillemer & White, 1989; Wakefield & Underwager, 1994), and on the speculation that the delayed maturation of the hippocampus of the brain somehow precludes memory and/or consciousness (Jacobs & Nadel, 1985; Schacter & Moscovitch, 1984). According to Wakefield and Underwager (1994), "Even if we accept that some memories may be retrieved from age two, no study supports the ability to recover memories at or near birth" (pp. 176).

The majority of psychotherapists surveyed by Yapko (1994a, 1994b), however, believe that accessing birth memory through hypnosis is possible. In an effort to assess their views on memory and hypnosis, 869 psychotherapists in clinical practice attending national and international psychotherapy conventions from all across the USA were presented with the Hypnosis Attitude Questionnaire (HAQ). The questionnaire consisted of eight items focused on determining the clinical worth of hypnosis from the psychotherapists' point of view. Two examples of these items are: "Hypnosis is a worthwhile psychotherapy tool" and "Psychotherapists can have greater faith in details of a traumatic event when obtained hypnotically than otherwise."

Pertinent to my discussion is item #5, "Hypnosis can be used to recover memories of actual events as far back as birth." Among all respondents, 53.8% agreed with this statement. Of those with formal hypnotherapy training, 59.4 % agreed; and, among those untrained in hypnosis, 55.6% agreed. Of the participants with MD degrees, 63.6% concurred. Those with Ph.D. degrees agreed 48.2% of the time, and those with MA degrees 58.5% of the time (Yapko, 1994a, p. 167).

Yapko (1994a, 1994b) explains these results as coming from what he feels is an erroneous but commonly held belief that all memories, even those from the earliest

stages of infancy, are stored and retrievable through special procedures like hypnosis. Loftus, Garry, Brown, and Rader (1994) called the results of Yapko's study "disheartening" and the psychotherapists' belief in the retrievability of near-natal memories "misconceptions," "unbelievable," and "memory myths" (p. 177). Their stated concern is that the beliefs would be communicated to clients.

> The harm is potentially great: False beliefs can be communicated from therapist to client. Therapist and client can engage in a misguided search for recalcitrant birth memories. Clients can be distracted from their true problems. Moreover, they may accuse others falsely, and thereby ruin the lives of other people. The field of psychotherapy suffers. And, what is worse, the disbelief spreads to those with true and genuine memories. (Loftus et al., 1994, pp. 176-179)

In response to Yapko and Loftus et al., Ewin (1994) infers that while controlled studies of birth memory may be scarce, it only takes one case to "void a statement that something never happens" (p. 175). He refers to two classic studies, one on imprinting with newly hatched birds by Nobel Prize-winning Konrad Lorenz (1935) and the other on human imprinting (Cheek, 1986; Rossi & Cheek, 1988).

Lorenz (1935) discovered that shortly after hatching, many birds will become as inseparably attached to any conspicuous moving object as they normally would be to their mother. These objects have ranged from a matchbox to a large canvas hide, and other living objects including people. This imprinting phenomenon occurs immediately after hatching, and the memory lasts for the life of the bird. While brief, the imprinting period is a demonstration of the concept of very early memory.

Cheek (1986) tested the persistence of imprinted birth memories by studying head and shoulder movements during the vaginal birth process. By hypnotically regressing adolescents he had delivered 16 years before, Cheek was able to show that they reproduced the identical head and shoulder movements they had at birth. Further, he noted that Cesarean section babies had no postural memories of delivery with later hypnosis. (This study is reviewed more thoroughly later in the chapter.)

I believe the point that Ewin (1994) makes is that

mainstream psychology's neglect of the phenomenon of pre- and perinatal memory is akin to throwing the baby out with the bathwater. That is, veridical studies like those of Cheek (1986) and Lorenz (1935) that stand the test of time and meet natural scientific standards are dismissed along with the empirical and anecdotal material of the field. The subject is written about and researched by alternative psychologists and virtually ignored or used to exemplify the improbable or the absurd by the mainstream. In an article denouncing "memory work" in psychotherapy for childhood sexual abuse (CSA), Lindsay (1997) describes what he seems to believe is a consensus of opinion:

"For one thing, there are documented real-world cases in which people recovered memories that are demonstrably false or extremely implausible. Examples include reported memories of bizarre and murderous satanic rituals; memories of abusive events during the first days of life, or even in the womb... The point of citing such examples is not to imply that all experiences of memory recovery should be attributed to the same mechanisms that give rise to illusory memories and false beliefs such as these; rather, the point is merely that such cases demonstrate that people can experience illusory memories of traumatic childhood events." (p. 7)

While my reason for citing Lindsay (1997) is to demonstrate a common and casually held disbelief in perinatal memory, his determination of the existence of illusory memory deserves some elaboration. The distinction between fact and fantasy in recovered memory can be difficult to determine (Person & Klar, 1994). Further, many clinicians believe, as did Freud, that the abreaction of illusory but believed-in events can be as healing as the abreaction of historically correct memory (Freud, 1893, 1896). Loftus (1997), however, alerts us to the danger involved when diagnoses are made based on false memory, resulting in accusations of abuse.

Current medical thought maintains that memory is not possible until the nerve endings have been myelinated, that is, until the fatty myelin sheath has formed around the large nerve tracts in the brain (Verny &

Kelly, 1982; Wade, 1996). Negating possibilities of consciousness or memory in neonates and casting doubt on the infant's capacity of pain perception (Anand & Hickey, 1987) science and medicine has maintained this supposition since the early part of this century. Based on the lack of myelination, many psychoanalysts view the newborn as "prepsychic," with little or no ego function (Fries, 1937, p. 117).

Myelination, however, is rarely mentioned in modern scientific texts on memory. It is known that it begins shortly after conception and is not completed until the age of 15 years (Chamberlain, 1988; Pearce, 1992). Its recognized function is to speed the conduction of nerve impulses, but the lack of myelin does not prevent their passage (Verny & Kelly, 1982). Anand and Hickey (1987) assert that the lack of myelination merely slows the velocity of nerve conduction in the neonate, which is offset by shorter interneuron and neuromuscular distances traveled by the nerve impulse (p. 1322). When speaking of perinatal memory, David Chamberlain (1988) suggests that the issue of myelination is actually irrelevant to memory function (p. 10).

The current study explores pre- and perinatal remembrance for purposes of healing. This healing apparently occurs as a result of bringing to consciousness unconscious memories of traumatic pre- and perinatal experience through the release of the defense mechanism of repression and from the resulting catharsis of painful feelings and emotions. Exact mechanisms involved in the healing are not understood. Speculations as to the processes that allow the memory recovery to occur involve the psychoanalytic concept of repression in concert with any or a combination of the following: cellular consciousness, muscular imprinting, theories of DNA/ RNA memory, neuropeptides, engrams, holonomic memory theory, in-utero clairvoyance, morphic resonance, and transpersonal coupled with fetal-oriented consciousness. Unfortunately, after many years of natural and psychological scientific research, the locus of memory and its function remain a mystery. Theories of these and other forms of memory and consciousness are reviewed in the following section of the dissertation.

While literature of the pre- and perinatal genre

does not hold sway with mainstream psychology, parts of a current decade-old, rather heated debate over the nature and veracity of recovered traumatic memory can apply. The controversy began in or about 1990 in response to sharp increases of reports of childhood sexual abuse recalled by adults (Wakefield & Underwager, 1994, p. 6). Many states changed statutes of limitation concerning sexual molestation to begin when the victim remembered the abuse even if that was many years after the purported occurrence. This has opened the courts to suits against accused perpetrators for events alleged to have occurred as far back as 40 years. Malpractice among psychotherapists is at issue, as well as the reputation of the field of psychotherapy, as accusations of the implanting of false memories are made (Alpert, 1995).

In the main, the argument rests upon whether the widely accepted Freudian concept of repression actually exists. Opponents are generally experimental or cognitively oriented psychologists, usually not psychotherapists, and often bear expert witness in the defense of accused perpetrators. Proponents, on the other hand, are usually psychoanalytic or psychodynamically oriented psychotherapists whose basic therapeutic tenets depend on the function of repression (Karon & Widener, 1998). Since most theories of pre- and perinatal memory recovery rest upon the concept of repression (Nichols, 1996; Ruch, 1986; Wade, 1996), the issue then becomes germane to this discussion. Therefore, I will narrowly cover all sides of the discussion pertinent to pre- and perinatal memory and consciousness.

The review also provides a brief overview of the psychoanalytic forerunners of pre- and perinatal psychology including Freud, Rank, Fodor, and Winnicott. Other topics discussed are, consciousness and memory within a holonomic paradigm; psychotherapies most often used to recover pre- and perinatal memory; utilizing ordinary and non-ordinary consciousness states; perinatal psychotherapy with infants and children; and the long- and short-term effects of routine obstetric intervention.

Birth is a change-over from one life to another. After nine months of peaceful developments, the human child is forced into a strange world by cataclysmic muscular convulsions which, like an earthquake, shake its abode to the very foundations. As if carried on the crest of a wave, the child is dashed not once or twice but without cessation for hours or days against the rock of the pubic arch. No adult could survive a similar ordeal, but Nature decreed that the child should. In its shattering effect, birth can only be paralleled by death.

Nandor Fodor (1949, p. 3)

Foundations

This section reviews some of the literature of the psychoanalytic founders of pre- and perinatal psychology. Included are the basic beliefs of Freud, Rank, Fodor, and Winnicott. In his early writings, Freud (1900/1965) recognized pre- and perinatal symbolism in the dream analyses of his patients. Further, at least initially, he attributed the source of all adult anxiety to birth trauma (1926a/1936, p. 74). Here are some excerpts from The Interpretation of Dreams (1900/1965):

A large number of dreams, often accompanied by anxiety and having as their content such subjects as passing through narrow spaces or being in water, are based upon phantasies of the act of birth. (p. 435)

Boxes, cases, chests, cupboards, and ovens represent the uterus and...also hollow objects, ships, and vessels of all kind.... (p. 389)

It was not for a long time that I learned to appreciate the importance of phantasies and unconscious thoughts about life in the womb. They contain an explanation of the remarkable dream that many people have of being buried alive: and they also afford the deepest unconscious basis of the belief in survival after death, which merely represents a projection into the future of this uncanny life before birth. (p. 436)

With his essential disbelief in any fetal cognitive function, Freud (1926b/1936) could not reconcile the concept of birth memory in psychoanalysis. “It is not credible that a child should retain any but tactile and general sensations relating to the process of birth” (p. 74). Hence, along with most of his associates, Freud moved away from the importance of birth trauma and toward the Oedipus complex to explain the origins of anxiety.

Inspired by Freud’s earlier concepts on this issue, Rank (1924/1929) remained steadfast on the importance of birth trauma to the course of psychoanalytic treatment. He held prenatal life to be a paradise and that believed every infant experiences trauma and hence anxiety in the first separation from mother, that is, birth. Rank (1924/1929) advocated that no psychoanalysis could be complete without its abreaction.

For in the analytic situation the patient repeats, biologically, as it were, the period of pregnancy, and at the conclusion of the analysis... he repeats his own birth for the most part quite faithfully in all its details. (p. 5).

He proposed that all experiences of anxiety and neurosis subsequent to birth are in actuality the individual’s attempt to abreact the trauma of birth (Grof, 1985, p. 338; Rank, 1924/ 1929). This theory was offered as the long sought after answer to the conundrum of the universal cause of all adult neurosis.

Rank's insistence that Freud was in error by placing the Oedipus Complex foremost in importance in psychoanalytic theory rather than the experience of birth eventually earned him the scorn and rejection of Freud and their colleagues, for Rank proposed replacing father’s importance in human psychological development with mother’s. That is, he chose to put birth trauma and therefore mother as the first trauma experienced by a child, rather than the Oedipus complex. This displacement would have moved the emphasis from a sexual etiology of psychological disorder to a physiological process (Rank, 1924/1929).

Fodor (1949), a psychoanalyst and patient of Rank's, believed that the trauma of birth was repressed material routinely expressed through dreams and

phobias. He wrote The Search for the Beloved from the collected case histories of his clinical practice.
Fodor did not believe in the consciousness of the neonate. Like Freud, he believed that the sense of touch was the only sense functioning prior to birth. He further held that the birthing process was much worse for the baby than for the mother, as the mother has intellect to help her mitigate the painful experience. Fodor (1949) wrote, “In the absence of consciousness of the purpose of the process, the child goes through an agony only comparable to the slow torture of death” (p. 15).

Like Hubbard (1950), Fodor (1949) felt that the "pain and shock" of birth as well as events before birth are encoded within the fetal organism regardless of its lack of consciousness. He stated, "The unborn child is nothing but an organism. Unconscious as it may be, the pain and fear reactions will still register" (p. 15).
This reasoning may seem confusing, but Fodor apparently believed intellect and consciousness to be the same and that experiences like "agony, pain, and shock" while registering in the "organism" do not necessarily require intellect or consciousness to be experienced.

D. W. Winnicott (1949/1958), a British child psychoanalyst of the object relations school, had a slightly different idea about the nature of consciousness in the neonate. He held that, from conception, the mind and body of the fetus are fused, gradually separating over the course of development. He worked with children in psychotherapy, often noting birth reenactment in their play. Winnicott influenced the primal therapy movement in Britain.

Historically, a split has always existed among psychoanalysts with regard to the existence of birth trauma and the possibilities of its resolution in the psychotherapy context.
This division continues to this day.

...I possess a distinct idea of body, inasmuch as it is only an extended and unthinking thing, it is certain that this I [that is to say, my soul by which I am what I am], is entirely and absolutely distinct from my body, and can exist without it.

Rene′ Descartes (1952, p. 98)

Memory, Consciousness, and a New Paradigm

John Locke, a seventeenth century English empiricist championed the concept of the “tabula rasa” or “clean slate” to represent the newborn mind as being completely blank until experience is imprinted upon it by the senses (Locke, 1813). William James did not depart much from that concept with his projection of the “blooming, buzzing, confusion” of the infant mind (James, 1890). The still popular developmental concepts of Piaget (1952) posit the newborn as having reflexes but not cognitive or social function, nor the ability to distinguish between itself and others. There are those, however, that suggest a primitive type of self-awareness or consciousness exists at birth and that with development a more complex consciousness emerges (Gallagher, 1996; Gibson, 1995; Kant, 1781, 1996; Legerstee, 1997; Spelke, Breinlinger, Macomber, & Jacobson, 1992). Taking very early consciousness concepts a step further, Wade (1996) posits the existence of two distinct but co-existing types, that of the (a) fetal and of the (b) transcendent levels of consciousness.

Juxtaposed views of consciousness such as these truly can be understood only if placed within the diverging scientific contexts from which they grew. To accomplish this orientation, a rudimentary grasp of the current, albeit disputed, shift in worldview from the mechanistic, reductionist school of thought to a “holonomic” or “holographic” paradigm is essential.

The Newtonian-Cartesian paradigm has dominated Western thought in its many manifestations for about the last 300 years. The prevailing belief has been that reality is fundamentally material, and that the universe is governed by a system of firm, unchanging, and absolute principles (Grof, 1985). This dominance can be seen in the “scientific method,” a process by which the scientific community establishes validity. The method calls for the controlled, reproducible, and witnessed execution of a given phenomenon. Generally, anything failing to fit into and meet this standard of reality testing has been denounced or held suspect.

Reductionist conceptions of reality have also held

sway over the “softer,” person-oriented sciences, like psychology, psychiatry, and sociology. With a rigid scientific standard being applied to research in these areas, progress has been severely held back. Personality and consciousness have been seen as the outcomes of drives or instincts, in Freudian terms, or as a result of the developing central nervous system (CNS). That personality could be a product of mind, continuing its development through lifetimes of experience would not be a viable concept. Further, there has been little support for consciousness research, for under Newtonian terms, consciousness must be shown to be a product of the brain or the CNS to be legitimate. Creativity has had nothing to do with a person’s connection with the whole of universal consciousness; rather, it is a consequence of genetics. Examples of phenomena thought to be hallucination, figments of the imagination, and products of the CNS, in the Newtonian-Cartesian paradigm of reality, are: inspiration, the power of prayer, the power of faith, meditation, spirituality, God, love, phenomenology, and pre- and perinatal memory or consciousness. According to Grof (1985): Mechanistic science tries to explain even such phenomena as human intelligence, art, religion, ethics, and science itself as products of material processes in the brain. The probability that human intelligence developed all the way from the chemical ooze of the primeval ocean solely through sequences of random mechanical processes has been recently aptly compared to the probability of a tornado blowing through a gigantic junkyard and assembling by accident a 747 jumbo jet. (p. 23)

Late in the nineteenth and early in the twentieth centuries evidence surfaced of certain physical phenomena that could not be explained completely with mechanical rules of causation. These rules had the effect of law until that time, at least for the “hard” sciences, such as, biology, chemistry, and physics. Rising inconsistencies heralded the beginning of a new system of thought. However, according to Wade (1996), these concepts are not really so new. “Physicists have been postulating a deep unitive reality for over fifty years, and Western philosophers (e.g., Plato, Plotinus, Spinoza, Hegel) have been postulating such a

reality for much longer" (pp. 8-9). Differing from Newtonianism on matters such as "time and space, matter and mind, and science and spirituality," the evolving paradigm has creative consciousness as its emphasis, rather than materialism (Wade, 1996, p. 2).

A greater understanding of creative consciousness can be gained with the help of the theories of the late David Bohm (1980, 1986a, 1986b). A theoretical physicist, Bohm was a prime mover of the new conceptions of mind and the universe. He described the nature of reality in general, and the nature of consciousness in particular as, "an undivided whole in perpetual flux." As such, the "empty space" concept of material science, in which humankind and other matter ostensibly exists, does not exist. To Bohm, space is composed of energy in constant movement -- "holomovement." Humanity is a mere portion of this energy, an uninterrupted, integral piece of the whole. Bohm derived his holographic or holonomic theory from the concept of holography, a three-dimensional, lensless photography, in which the whole of the image can be seen in each of its parts. As integral parts of the holonomic or holographic universe, we can imagine that each of us contains information about the whole or any part of the universe. (Bohm, 1980, 1986a, 1986b; Grof, 1985; Pribram, 1982; Weber, 1982).

Bohm (1980, 1986a, 1986b) described holomovement as being comprised of the "implicate" and "explicate" orders, two interpenetrating and coexisting states. Although intrinsically one unit, the explicate order represents physical reality, bound in time and space, and the transcendent or implicate order consists of pure energy (infinite or absolute). Seen in this way, Newtonian reality would be the manifest or explicate realm of the holomovement which is only a fragment of the whole and the material expression of the implicate order. Under this theoretical construct, our brain, holographic by nature, acts as a transducer of the holographic universe, making contact with pure creative energy and using it to construct concrete reality. In other words, humankind, mostly unconsciously, is creating its own reality. Pribram (1982) restates these ideas,

Our brains mathematically construct "concrete" reality by interpreting frequencies from another dimension [the implicate or infinite], a realm of meaningful

patterns, a primary reality that transcends time and space. The brain is a hologram, interpreting a holographic universe. (p. 5)

Motivated by increasing frustration with unmet needs, the new paradigm is emerging into being like an infant individuating into autonomy. According to Grof (1985), a sure sign of the emergence of a holonomic paradigm is that more and more individuals are questioning the focus on materialism and turning inward for answers. He notes a growing interest in the evolution of consciousness and consciousness research. These expansions in concepts of consciousness like those described by Bohm (1980, 1986a, 1986b) and Pribram (1971, 1982) may someday allow a fuller understanding of how the phenomena of fetal and transcendent consciousness function concurrently (Wade, 1996) and reflect Bohm's explicate and implicate orders.

Fetal consciousness, for example, capable of nascent cognition, learning, and inchoate individuation is thought to be contingent on the CNS and possibly some physical structures such as RNA, or other biochemical messengers; transcendent consciousness is considered to be mature and unchanging (Wade, 1996, p. 32). The following studies exhibit research illuminating the nature of both types of consciousness. I could not find commentary or studies in contrast to this work in any refereed journal. Perhaps, as Chamberlain (1988) suggests, the focus of Western science on the immaturity of the infant brain has prevented the recognition of newborn and fetal competence. Extensive searches revealed studies on the intelligence and capacity of newborn kittens and monkeys but not of human neonates. Studies of fetal conditioning and sensation and studies of older human infant capabilities are available but do not apply to my study of pre- and perinatal memory and consciousness.

The Prenatal University Stimulation Program (Van de Carr & Lehrer, 1988) is designed to encourage expectant families to interact with prenate(s). Two 5-minute sessions per day of interaction between family and fetus through the mother's abdominal wall are scheduled. Using tactile communication such as rubbing and patting in response to fetal kicks at 20 weeks, and then more complex musical tones and verbal stimulation at 32 weeks, very early relationships are

established. The program is followed-up after birth with similar interaction. Sessions are scheduled during times when fetal activity is greatest.

The authors described the following incident as an unexpected result of their project. A mother who had participated in the Prenatal University program for her first pregnancy was again expecting a child. At the fifth month of pregnancy she showed her swollen abdomen to the 16 month old daughter who had experienced the prenatal stimulation course. The little girl went to her mother and began patting and rubbing her abdomen, saying, “pat, pat, pat, rub, rub, rub,” exactly as she had been taught in utero. She had apparently had no other exposure to the programmed stimuli.

Van de Carr and Lehrer (1988) point out that the program is designed so that the parents and siblings begin to identify the prenate as an individual before birth. The fetus in this program is considered to be an understanding and responsive being. These attitudes form the basis for the positive, respectful, and loving relationships that develop consistently as a result of program participation, including: (a) significant improvement in infant performance, (b) consistent reports of positive bonding between parents and child, and (c) and overall development of positive patterns in parent-child and parent-parent interactions.

Sallenbach (1993, 1994) interacted with his prenate daughter, Claira, by applying greetings from family members, bell sounds, musical arrangements, and focused abdominal lighting to his wife’s abdomen during her pregnancy. Activities were divided into five major "domains": (a) social, including greetings from family members, brief conversations, and good-byes, (b) language, including vowel sound discriminations, (c) visual, involving responses to light movements, (d) auditory, involving locating bell sounds, and (e) music, including responses to musical arrangements. Claira responded distinctly and predictably with kicking, rolling, rhythmic, and hand movements. She used hand movements to respond to the social games, the visual games were met with kicking movements, the auditory games with rolling movements, and the musical arrangements with rolling and rhythmic patterns. As the pregnancy progressed Claira was

apparently able to respond more distinctly and to sustain her responses for longer periods of time.

Ultrasound, fetal audition, and prenatal learning studies are also supportive of the concept of fetal consciousness. Piontelli (1992) demonstrated interactive, affectional behavior among prenates in her ultrasound studies of twins. (See Chapter 1.) Fetal responses to the penetrating intrauterine needles of amniocentesis have been recorded by ultrasound. A 24-week-old fetus was observed being contacted by a needle while receiving amniocentesis for possible Rh incompatibility. This needle contact "...precipitated rotation of the torso, and a 'trophic' [concerned with nourishment] type of response in which one arm located and repeatedly contacted the needle barrel" (Birnholz, Stephens, & Faria, 1978, p. 538). In another study by Ianniruberto and Tajani (1981), a fetus at 24 weeks of gestational age while bringing a hand towards his mouth, was observed leaning his head forward in order to introduce and begin to suck his thumb (1981, p. 180).

While these studies could represent greater behavioral maturity than normally expected of the 24 week fetus, proponents of prenatal consciousness may attribute more sophisticated motives to the fetus than actually exist. For example, when I reviewed various accounts of Birnholtz et al. (1978) written by other than the authors, the fetus was reported to be "repeatedly striking," "taking aim at," or to have "attacked" the needle barrel. The original study neither stated nor implied such actions.

Examples of actual perinatal learning can be seen in the next studies. De Casper and Fifer (1980) found that newborns could cause a tape recorder to produce their mothers' voices by sucking on a nonnutritive nipple in a certain way. They demonstrated significant preference for their mothers' voices over the recorded voices of other females. In a similar study DeCasper and Spence (1982) discovered that newborns will suck faster or slower to hear Dr. Seuss stories like "The King, the Mice and the Cheese" or "The Cat in the Hat Comes Back" if those stories had been read to them in utero.

Another study demonstrating neonatal learning ability showed that newborns exposed to the theme song for a "soap opera," by virtue of their mothers having

watched it regularly while pregnant with them, were soothed upon hearing it after birth. Newborns in the control group who had not heard the song during their pregnancy were not affected by the music (Hepper, 1988).

The source of transcendent consciousness has been described as mature and unchanging. It is thought to be complementary of fetal consciousness but separate from the body. This consciousness is thought to remain spatially and temporally limited to an area surrounding the fetal body, or the mother. At some time during the perinatal period, it is assumed that the transcendent source becomes attached to the fetal body and has less freedom. This usually happens at about the same time that measurable brain waves begin (third trimester). The two sources of consciousness, fetal and transcendent, are thought to become inextricably attached by the second day after birth. (Wade, 1996, p. 53)

Much of the evidence for a transcendent pre- and perinatal consciousness is gathered from subjects in an altered state of consciousness, such as hyperventilation, drug- induced psychotherapy, or hypnosis. Altered states, however, are generally dismissed as fantasy by reductionist psychologists, and considered useless as evidence of very early memory (Wade, 1996, p. 31). As such, the literature containing examples of fetal and transcendent consciousness is found in alternative journals and books. It can be recognized as having states of awareness that witness the fetus's or neonate's point of view, as well as the thoughts and feelings of those in the surrounding area. Further, it can demonstrate this awareness of varying perspectives and locations at the same time.

Wambach (1979/1981) claims to have demonstrated transcendent consciousness when she hypnotized large groups of adults regressing them to the perinatal realm and before. She asked questions pertaining to how individuals chose their families, when they "entered the fetal body," what birth was like, and so on. The majority of Wambach's subjects were people of diverse belief systems, many of them not subscribing to notions of reincarnation or birth regression. Nonetheless, they related stories of an out-of-body orientation with regard to the birth experience. They

spoke of being conscious, intelligent, decisive individuals, without a body, prior to birth (p. 8).

Wambach's study can be criticized for never having been published in a scholarly journal. Further, some of the hypnotic techniques used were suggestive, like calling the sessions a "birth trip" (p. 17), or guiding the participants to "out of body" (p. 15) and "before birth" experiences (p. 17). The study was cited by Wade (1996, p. 52), however, as a prime example of transcendent consciousness.

The late Graham Farrant (1987), a psychiatrist, told of personally reexperiencing an abortion attempt during primal therapy. Such early memory could represent transcendent consciousness. He wrote,

> I had a toxic headache, confusion state, irritability, terror, rage, all confusedly mixed. It was like a jigsaw puzzle that I would put a piece of each time I primaled and one day the final piece went in and I knew. (p. 32)

According to Farrant, he confronted his 79 year old mother with having taken pills and a hot bath in an attempt to abort him. She burst into tears and exclaimed that it was true but that she had never told anyone. He and his mother became much closer as a result of the communication.

According to Chamberlain (1988) and Rhodes (1996), occasional birth accounts surface among toddlers between the ages of 2 and 3 years and stop before the age of 5 years. Given the sophistication of the observations and the sensual nature of the accounts, it would appear that a combination of transcendent and fetal consciousness is involved. Chamberlain (1988) gives an example:

> After assisting at a birth, Cathy, a midwife, breast-fed the newborn to quiet her while the mother was bathing. She said she felt a little guilty about being the first to nurse the child. Less than 4 years later, the little girl recounted the tale to Cathy. She said, when asked if she remembered her birth, "Yes!" and proceeded to give an accurate account of who was present and their roles during labor and delivery. She described the dim light in the womb and the pressures felt during birth. Then the child leaned up close and whispered in a confidential tone, "You held me and gave me titty when I cried and Mommy wasn't there." (p. 103)

Becky, the 2-year-old child of clients' of mine was looking at magazine photos of developing monkey fetuses. Her mother was explaining what some of the pictures meant when Becky, apparently reflecting on her own birth experience, gripped her forehead and exclaimed, "It was real tight on my head" (personal communication, 1996).

Most of the following memory conceptions present evidence in contrast with the Newtonian-Cartesian paradigm and exemplify the movement toward a holonomic universe.

Often referred to as "cellular," "tissue," "body," or "somatic" memory these theories conflict with the mechanistic viewpoint that memory and consciousness are contingent upon the maturity of the CNS. Some offer plausible explanations for the phenomena of pre- and perinatal memory. Brandon et al. (1998) and Smith (1995) contend there is no empirical evidence to support this view.

Concepts of the bodily retention of memory can be traced back at least 100 years to Pierre Janet (1889) who believed that intense emotional responses are dissociated from consciousness and stored viscerally as anxiety and panic, or as visual images of nightmares and flashbacks. In Freud's (1919/1954) studies of wartime neuroses he declared that his patients had been physically fixated to war trauma.

In search of engrams, the ostensible locus of memory, Karl Lashley trained experimental animals, systematically damaging parts of their brains, for 30 years. His conclusion was that removing parts of the brain worsened the animals' performance but could not eradicate what they had learned (Lashley, 1929; 1960). Lashley's conclusion that memory cannot be localized in any one area of the brain has been criticized on the basis that his experiments were based upon that idea (Wolfgram & Goldstein, 1987).

In contrast, Penfield (1959) in conducting brain surgery with epileptic patients, arrived at conclusions opposite from Lashley's localization results. By electrically stimulating the temporal lobes of the brain, the physician elicited early childhood memories in some of his patients. In spite of this, Penfield (1975) believed strongly that the human mind is not attributable to the CNS. About this

and in response to a colleague he wrote:

> That is the correct scientific approach for a neurophysiologist: to try to prove that the brain explains the mind and that mind is no more than a function of the brain.
> But during this time of analysis, I found no suggestion of action by a brain-mechanism that accounts for mind-action (Chapter 17). That is in spite of the fact that there is a highest brain-mechanism and that it seems to awaken the mind, as though it gave it energy, and seems itself to be used in turn by the mind as "messenger." Since I cannot explain the mind on the basis of your "assumption," I conclude that one must consider a second hypothesis: that man's being is to be explained by two fundamental elements. (p. 104)

The following studies suggest a physical basis for memory that involves the cellular chemistry. They also may indicate a coding of peptides for memory (Wolfram & Goldstein, 1987).

McConnell (1962) trained flatworms to turn away from light. He then discovered that by feeding the trained worms to a group of untrained worms they would learn to avoid the light more quickly than the original group. He concluded that the latter group learned more quickly because chemicals associated with the conditioned response were made available to them.

In a similar study, Ungar (1967) trained normally nocturnal rats to avoid the darkened part of a box by placing electrified screens in the area. He then made extracts from the rats' brains and discovered the presence of a new peptide. By artificially duplicating the peptide and injecting it into untrained nocturnal rats, he found the latter group of rats would automatically avoid the darkened part of the cage.

Pribram (1971) advanced his holographic theory of memory storage in Languages of the Brain. He posited that memory is stored in every cell of the body as opposed to in the CNS alone. As such, each cell contains information about the whole. Further, he felt that the brain may function as a "spectral analyzer," recording images by holography and distributing information to all of its parts (Pribram, 1986).

Rossi (1990) and Buchheimer (1987) agree with Pribram (1986) that memory storage is a part of the cellular

chemistry of the body, and they hypothesize that it is connected with protein synthesis. Since protein is in every cell and RNA serves as a messenger to and between the cells, memory could be encoded and stored in the cells as protein is synthesized. Buchheimer suggests that the elusive “engram” or memory trace is really an electrical function of the cells, working in complement with RNA, the real memory storage. An example of how the cellular chemistry of the body might hold memory follows.

Larimore and Farrant (1995) used the term “cellular consciousness” to refer to memories arising out of primal therapy experiences of life as a sperm, egg, blastocyst, or zygote. They felt that these memories could not be explained by any other type of memory or consciousness except cellular. That is, at the time of conception there is no physical substrate in place to explain memory storage besides cellular retention. They apparently did not consider the possibility of transcendent consciousness which could also account for memories of life as a sperm or ovum.

The late L. Ron Hubbard (1950) was a controversial author who wrote about the pre- and perinatal realm and memory. Hubbard taught the psychotherapeutic techniques he had created based on Freudian or psychodynamic theory. While never searching for localized memory traces, he sought and often accomplished the "clearing" of engrams from his followers' mental and physical systems. This could be seen by improvements in mental and physical health. Similar to Fodor (1949) Hubbard believed that pre-and perinatal trauma could be stored in the fetus or infant without its having consciousness. He employed the term “engram” to this end. “The engram is a moment of unconsciousness, containing physical pain or painful emotion and all perceptions, and is not available to the analytical mind as experience” (p. 61). Hubbard (1950) stated, “The engram is not a memory; it is a cellular trace of recordings impinged deeply into the very structure of the body itself” (p. 185). Unfortunately, he never had his work published in reputable journals. He and his Church of Scientology instead developed ill repute and notoriety in the public eye. Grof (1985) sums up the mixed feelings I have about including Hubbard's work in this literature review:

There are far-reaching parallels between the concepts presented in this book [Beyond the Brain, 1985] and L. Ron Hubbard's controversial, Dianetics and Scientology (1950). The comparison of the two systems - since there are many differences as well as similarities - would require a special study. Unfortunately, Hubbard's remarkable insights have been discredited by their practical application within a dubious organizational structure (The Church of Scientology) lacking professional credibility and compromising itself by its pursuit of power. However, that fact should not diminish their value for an open-minded researcher who will find scientology to be a gold mine of brilliant ideas. (p. 196)

In many ways, Hubbard appeared to be ahead of his time. For example, Dianetics, published in 1950, reflects his belief in the cellular recording of events from conception on, the engram. Rossi (1990) and Buchheimer (1987) published similar hypotheses but at much later dates. Further, included in Dianetics is Hubbard's conviction that the fetus can suffer irreversible damage from attempted abortion. This idea surfaced again much later in the work of therapists like Emerson (1987), Farrant (1987), and Findeisen (1993).

Sheldrake (1982/1995) believes that nature, not just human beings, has a memory on which it draws and to which it contributes. “Morphogenetic fields” is his name for memory specific to particular species, chemical processes, and simple and complex life forms that shape developing cells, tissues, and organisms. They provide the memory template for reproduction through vibration, like upon like, throughout nature. Sheldrake believes that this memory theory, “morphic resonance,” provides some understanding for past-life memories, survival of bodily death, telepathy, and ritual.

The following contributions represent more recent evidence for somatic memory and possibilities of pre- and perinatal memory recording. Research conducted outside the pre-and perinatal context supports the idea of primitive brain structures being sufficiently developed before birth to record traumatic experience. This recorded trauma is believed to profoundly affect subsequent brain development, behavior, and patterns

of thought. By demonstrating how impaired affectional bonding at birth negatively affects brain development and subsequent behavior, Prescott (1995) showed substantial parallels between this and post traumatic stress disorder (PTSD), except at a developmental age earlier than ever before considered.

Studies of traumatized individuals confirm consistent physiological response to stimuli reminiscent of traumatic incidents, such as heart rate, skin conductance, and blood pressure (Kolb & Multipassi, 1982; Pitman, Orr, Forque, de Jong & Claiborn, 1987; van der Kolk & Ducey, 1989). These symptoms are also recorded by Grof (1985) and Janov (1983) when referring to individuals reexperiencing birth. About PTSD survivors van der Kolk (1996) writes, "The highly elevated physiological responses that accompany the recall of traumatic experiences that happened years, and sometimes decades before, illustrate the intensity and timelessness with which traumatic memories continue to affect current experience" (p. 5).

According to van der Kolk (1996) people with PTSD chronically suffer from the persistent activation of the biological stress response. Increased levels of epinephrine and norepinephrine, abnormally low urinary cortisol excretion, and increased amounts of lymphocyte glucocorticoid receptors are common in PTSD sufferers. He points to the development of decreased CNS seratonin levels in inescapably shocked animals, and the fact that seratonin re-uptake blockers are effective pharmacological agents in the treatment of PTSD as evidence of the physical memory of trauma. Further, Van der Kolk (1989, 1996) maintains that the limbic system, that part of the CNS which records the emotions and behaviors necessary for survival, is critically involved with the storage and retrieval of memory. This information coupled with Pert's (1986, 1987a, 1987b) and Pert, Ruff, Weber, and Herkenham's (1985) contention that the limbic system is partially mature at 4 weeks of gestation and fully formed by the third trimester of prenatal life lends additional support for the feasibility of pre-and perinatal somatic memory.

Juxtaposing models of traditional infant ego development with conceptualized prenatal ego development, Wade (1996) notes the similarities. Both types of ego development begin with an

"undifferentiated state when the individual's needs are fully met in an oceanic embeddedness" (p. 37). Prior to birth, the fetus is symbiotic with the uterus or amniotic sac (Grof, 1975, 1985). After birth, symbiosis is composed of the infant, mother, and environment (Kegan, 1982; Loevinger, 1976; Sullivan, 1953). The second stage of this process witnesses the environment of the pre- and post-natal child becoming "hostile," in that it fails to meet the needs of the fetus or baby. Verny and Kelly (1982), Verny (1987), Grof (1979, 1985), and Grof and Bennett (1990) suggest that fetal individuation, that is, the gradual process from symbiosis with mother to the establishment of firm ego boundaries, begins sometime during the second trimester and culminates before birth. Wade (1996) purports that "a periodically hostile uterine environment draws the attention of the fetus out of embeddedness" (p. 38). Hypothesizing that the impetus for fetal and infantile ego development is, in large measure, the same, Wade points to frustration arising from failed attempts at getting needs met as the catalyst for increased development. An example of this might be an infant learning to feed itself, in part, because waiting for mother is too frustrating.

The question might arise then of why the neonate would begin the process of separation and individuation after birth when the process was ostensibly completed in utero? The suggested answer is that massive repression of the memory of the trauma of birth submerges the memory of fetal individuation along with it, creating the need for its recurrence later (Wade, 1996, p. 39). This researcher proposes that the process of separation and individuation occurs repeatedly from conception throughout childhood with age-appropriate adaptation along the way. Surely the latency and adolescent-aged child can be seen to be in a continual process of separation and individuation resulting in greater maturity and autonomy over the years.

Repression or Dissociative Amnesia

A Freudian concept central to this discussion is that of "repression." Since most theories of pre- and perinatal memory recovery rest on the veracity of this

defense mechanism (Fodor, 1949; Nichols, 1996; Ruch, 1986; and Wade, 1996), it is important to define it and to discuss its relevance. Given, however, that pre- and perinatal memory is not generally taken seriously by mainstream psychologists and therefore not researched or written about by them, this discussion is taken instead from that literature's current debate over recovered memories of childhood sexual abuse (CSA).

Current use of the concept of repression includes the unconscious forgetting of trauma related and not to the libidinal (sexual) drive but threatening to the integrity of the self. Another definition with a less traumatic connotation is, "Repression simply means removing something from conscious awareness or keeping something out of conscious awareness because of the unpleasant affect connected with it" (Karon & Widener, 1998, p. 483). Freud (1896/1974) used the term repression to represent a universal psychological defense mechanism which prevents the awareness of painful or unacceptable wishes, thoughts, fantasies, and memories. Early in his career Freud wrote that repression kept CSA memories from consciousness, causing the individual to express them instead in the mental disorder of "hysteria." Later, acquiescing to the public outcry against that determination (Bowers & Farvolden, 1996, p. 362), Freud (1905/1959) deemed those unacceptable memories to be mostly fantasy. Unfortunately, the current debate over traumatic memory recovery, CSA, and concepts of repression does not exist solely for academic or clinical clarification. As it parallels the 100 year old Freudian dilemma over the veracity of CSA memories, many of the same social, political, legal and economic issues fuel this controversy. Fascinating as this dispute is though, it is less than germane to the current study. Instead, I will try to focus on and tease out aspects of the literature that are more pertinent to the issue of pre- and perinatal recall.

Most CSA and most, if not all experiences of birth can be considered traumatic. As such, and because the defense mechanism of repression is said to protect the integrity of the self from traumatic overload and because everyone theoretically represses or maintains no memory of birth, I feel that this literature, with certain qualifications, can provide material worthy of

consideration. One obvious drawback to the comparison of pre- and perinatal memory with that of early memories of CSA is that the brain development of young children is far advanced over that of prenates and perinates. Studies measuring the memory capacity of young children have shown that it increases dramatically with maturity (Campbell & Spear, 1972; Campbell, Misanin, White, & Lytle, 1974; Terr, 1991, 1994). Therefore, attempting to explain pre- and perinatal memory, especially with the vividness and clarity that sometimes manifests, with the CNS theories used to explain infantile amnesia and repression is fruitless. Still, veridical studies documenting pre- and perinatal recall have exhibited a viable mechanism, albeit to date unidentified, which permits detailed recall after many years of amnesia (Chamberlain, 1986; Grof, 1985, Wade, 1996). Further, credence should be given to the verity of cases of traumatic perinatal recall that result in total body involvement, with phenomena such as: forceps marks showing on the head, great difficulty in breathing to the point of cyanosis, and verified reports of the amelioration of physical or psychological impairment (Grof, 1985; Janov, 1983). These data present ample evidence of repression, and solve the conundrum of whether or not it exists. That this is denied categorically, by most psychologists, however, ostensibly because belief in infantile amnesia does not permit concurrent belief in pre- and perinatal recall without the discomfort of cognitive dissonance, is where the Newtonian paradigm breaks down and a holographic point of view must naturally succeed. A holographic viewpoint sustains concepts such as that the mind is not the brain, and that the brain and the mind sometimes function together, and sometimes not.

Among psychologists, there is a range of opinion about repression from complete rejection to fanatical pursuit. Holmes (1974, 1990); Loftus and Ketcham (1991, 1994); Ofshe and Watters (1993, 1994); and Pope and Hudson (1995) do not believe that the mechanism exists. In the recovered memory dispute this group is known as “false memory advocates.” Brandon, Boakes, Glaser and Green (1998) expressed this point of view, “There is no empirical evidence to support either repression or dissociation, though there is much clinical support for these concepts” (p. 304). Bowers

and Farvolden (1996) believe that repression does exist but that it is rare (p. 359). In their examination of the evidence in favor of and against repression they suggest that not everything need be proven in a laboratory. Alpert, Brown, Ceci, Courtois, Loftus, and Ornstein (1996), the APA working group on the investigation of memories of childhood abuse, concluded that it is possible to recover long forgotten memories of childhood abuse, and conversely, to have false memories created through suggestion.

Among pre- and perinatal theorists, therapists, teachers, and researchers there is virtually no disagreement that effective treatment for pre- and perinatal trauma involves the bringing to consciousness of the repressed material surrounding it. Helping participants to integrate catharted feelings, emotions, and memories is also important, but fundamentally, the release of repressed energies is central to resolution.

A plethora of books and journal articles has been published in the last decade expressing these and other opinions, and arguing the viability of concepts of repression, dissociation, suggestion, false memory implantation, hypnosis, incest survivor support groups, and certain types of suggestive psychotherapies (Alpert, 1995; Karon & Widener, 1998; Pendergrast, 1997; Porter & Lane, 1996; Read & Lindsay, 1997; Yapko, 1994a, 1994b). Studies profferedto demonstrate the mechanism of repression are nearly always met with a critique of their methodological weaknesses and may be eschewed completely as a result. Scheflin and Brown (1996) point out the value of less than perfect studies of repression, “It should be noted that even if these studies are methodologically flawed in some manner, that does not mean their conclusions are false, or that the opposite of their conclusion - dissociative amnesia does not exist - is the correct conclusion” (p. 145). This may be another example of Western science throwing the proverbial baby out with the bathwater.

Pope and Hudson (1995), calling for more scientific research on the subject of repression, state that the following criteria must be met for proof of the phenomena to be established:

Evidence that the traumatic events occurred such as, emergency room documentation of CSA, or corroboration by a perpetrator.

Evidence that the trauma was repressed, excluding: cases where victims simply tried not to think about the trauma (suppression); pretended that the events never occurred; appeared to derive secondary gain by claiming to have amnesia (perhaps to avoid embarrassment, or to extend a legal statute of limitations); and cases of biologically induced amnesia, such as: seizures, alcohol and drug intoxication, head trauma, or children under 6 years due to infantile amnesia.

Evidence that the abuse was sufficiently traumatic that no one would reasonably be expected to forget it. (p. 122)

Interestingly, anyone with a perinatal memory of a documented trauma could meet the above standards for proof of repression and birth memory with the exception of the infantile amnesia exclusion. Most hospital records provide proof of such events as: asphyxiation, use of forceps, Cesarean section, breech birth, vacuum extraction, and other perinatal trauma. Repression and perinatal memory would be clearly shown if details of the birth were never told to the participants by their family or physician, and subsequent recall occurred. In fact, that is what Chamberlain (1986) did with his study hypnotizing mother and child pairs to the child's birth. (See the hypnosis section of this chapter.)

By way of example of the challenges facing researchers attempting to prove a concept such as repression to the specifications of those social scientists disbelieving of it, I have selected a study designed to demonstrate this mechanism in women with histories of CSA and to assess the accuracy of their memories (Williams, 1994). It provides an avenue to document objectively abuse and the subsequent amnesia for that abuse. The investigation has been widely published and reviewed in refereed journals, both positively by advocates of repression and critically by those who disbelieve it.

Williams (1994) interviewed 129 mostly African American women who, as children, had been brought to a city hospital emergency room in the years 1973 to 1975 for treatment of sexual abuse and forensic evidence collection. The first evidentiary requirement was thus

established.

The women were aged 10 months to 12 years at the time of the abuse. They were contacted by the researchers and interviewed approximately 17 years later, when they were ages 18 to 31. The participants were told that they had been selected for a follow-up study from the records of people who had gone to the city hospital during the years 1973 to 1975. Detailed questions about each woman's history of sexual abuse were asked by the researchers. They were also asked if anyone in the family had ever been in trouble for their sexual behavior. If the participants did not report the known episode of abuse after these questions and statements, they were not asked directly about their documented visit to the hospital (Williams, 1994). Because it was a nonclinical study, that is, the interviews were not conducted by nor the women referred by psychotherapists, any suggestion of therapeutic influence was eliminated.

Forty-nine (38%) of the 129 women did not report the abuse event to the interviewer, 42 (32%) said they were never abused, and although they had recalled the memory at some time prior to the interview, an additional 21 (16%) said that they had experienced some period in the past when they did not remember the abuse. Williams (1994) believes that the majority of the non-reporting cases were genuinely amnestic for the abuse. She supports this contention by pointing out that about 50% of the women talked openly and gave detailed descriptions of other personal or embarrassing childhood experiences, including other episodes of sexual abuse, while not mentioning the index occurrence.

Regarding the accuracy of the memories of the abusive incident, the researcher reported that the women with recovered memories had no more inconsistencies in their accounts than the women who had always remembered. A comparison of the memories of both groups of women with the documented reports from 17 years earlier were essentially the same (Williams, 1994).

Pope and Hudson (1995) suggest that "...it is hazardous to conclude that Williams's non-reporters actually had amnesia" (p. 124). They felt that a "clarification interview" should have been held to confront the non-reporters with the facts of

their cases. The Pope and Hudson outlined set of criteria is difficult to meet. In addition to failing to meet those guidelines, though, other criticisms are sometimes made which can put researchers in a "Catch-22" bind. Scheflin and Brown (1996) point out Williams's (1994) risk of undue suggestive influence if she chose to do a clarification interview. They wrote:

> False memory advocates try to have it both ways: first they claim that therapy interviews are unduly suggestive to the point of implanting false memories, and then they claim that research interviews are "clarifying," with the implication that research interviews are somehow free from suggestive effects while therapy interviews are not. Following false-memory reasoning, a follow-up interview could not have been included in the Williams study if the intention was to minimize suggestive effects in the research interviews. A free recall interview, as was exemplified in the Williams study, is the only way to minimize the memory commission error rate, while the leading or misleading questions characteristic of a "clarifying" interview would increase this error rate. (p. 170)

A further criticism of the Williams's study by Pope and Hudson (1995) and Wakefield and Underwager (1994) is that 25 (51%) of the non-reporters experienced the documented episode of abuse at age 6 or younger, during that period of development associated with infantile amnesia. Also, they refer to one third of the subjects who experienced "only touching and fondling," indicating that this type of abuse might have been less or not traumatic and thereby merely forgotten in the ordinary sense of the word (p. 125). Pope and Hudson concluded, "Thus, Williams's 38% rate of non-reporting might be readily explained as a combination of cases of early childhood amnesia, cases of ordinary forgetfulness, and perhaps many cases of failure to report information actually remembered" (p. 125). They decided, "Thus, present clinical evidence is insufficient to permit the conclusion that individuals can repress memories of childhood sexual abuse" (p. 121).

Regarding Pope and Hudson's reference to early childhood amnesia as partial explanation for the high non-reporting rate in Williams's study, Scheflin and

Brown (1996) pointed out that if childhood amnesia were responsible for the high non-reporting rates, the younger women in Williams's sample would be expected to have a higher prevalence rate of amnesia than the older women, which was not the case (p. 169). No significant differences were found in the rate of amnesia for the index episode between the older and the younger women in the study (Williams, 1994). After analyzing this study and 24 others, Scheflin and Brown (1996) concluded,

> These studies, when placed together, meet the test of science - namely, that the finding holds up across quite a number of independent experiments, each with different samples, each assessing the target variables in a variety of different ways, and each arriving at a similar conclusion. When multiple samples and multiple methods are used, the error rate across studies is reduced. Even where a small portion of these cases of reported amnesia may be associated with abuse that may not have occurred or at least could not be substantiated, the great preponderance of the evidence strongly suggests that at least some subpopulation of sexually abused survivors experience a period of full or partial amnesia for the abuse (p. 179).

Conclusions regarding the Williams's (1994) study and the like have been virtually unanimous among false memory advocates. Despite the acknowledgment by Loftus, Garry and Feldman (1994), that Williams demonstrated genuine memory failure, they concluded, along with Ceci and Bruck (1995) and Wakefield and Underwager (1994), that most of the evidence for repression can be explained with normal forgetting processes, thus rejecting her findings. Normal forgetting processes, however, fail to explain the repression of pre- and perinatal trauma. Conversely, the derepression of that trauma does not occur with normal remembering. Techniques that create altered or non-ordinary states of consciousness are generally used to assist in the process.

Yapko (1994) defines "recovered memory therapy" as a label that describes the practices of a heterogeneous group of psychotherapists that share a particular set of beliefs. Primary among those beliefs is that their client's present symptoms are caused by past traumatic sexual abuse, and that recovering related memories is

essential to their amelioration. Olio and Cornell (1994) deny that such a group of clinicians exists. "In fact, the creation of these pejorative terms seems to create an erroneous caricature that oversimplifies and distorts the very issues these groups wish to address" (p. 78). Whether or not a group of recovered memory therapists actually exists, many of the memory recovery therapies used for the treatment of CSA and generally critiqued negatively by Yapko (1994) and his colleagues (Brandon et al., 1998; Ceci & Loftus, 1994; Kihlstrom, 1997; Kihlstrom & Evans, 1979; Kihlstrom & Harachiewicz, 1982; Pope & Brown, 1996; Read & Lindsay, 1994, 1997), are the same as those used to access pre- and perinatal memories.

The therapies include hypnotic techniques such as age or birth regression, guided imagery, and hypnotherapy, but any altered states therapy can be counted among their ilk. All of these and other therapies used by therapists to recover memories of CSA have been denounced by false memory advocates. The British Royal College of Psychiatrists' Working Group on Reported Recovered Memories of Child Sexual Abuse (Brandon et al., 1998) formed to "examine objectively the scientific evidence" [for recovered memory therapies]. Brandon et al. (1998) write,

> We concluded that when memories are 'recovered' after long periods of amnesia, particularly when extraordinary means were used to secure the recovery of memory, there is a high probability that the memories are false. (p. 296)

> There can be no justification for the use of memory recovery techniques which involve significant departure from normal interview or psychotherapy techniques. In particular, consciousness-altering techniques involving drugs, hypnosis, prolonged interrogation or strong suggestion should not be employed as a means of 'recovering' memories whose existence is hypothesized....memories from before the age of four years...are not credible. There is a reasonable chance that they will wither away if not reinforced by attention. (p. 304)

The authors of the survey felt that opinions of advocates for the use of recovered memory therapies held "great conviction" but were often not supported

by evidence. Some of the evidence they presented denouncing these therapies is valid and should be considered thoughtfully, such as the suggestibility factor of the work, and the prevalence of false memory and confabulation (Brandon et al., 1998). The group was remiss, however, in mentioning the documented benefits of altered states therapy (Chamberlain, 1986, Emerson, 1978, 1987, 1998; Grof, 1973, 1975, 1979, 1985; Janov, 1983, 1991) or of the many existing veridical studies of repression and neonatal recall (Chamberlain, 1986; Cheek, 1974, 1986; Mutter, 1990).

False memory and confabulation are major issues in the current debate over the veracity of repression and recovered memory therapies. False memory advocates contend that most if not all recollections of CSA in adulthood either constitute false memory or confabulation, or that the memories had never really been forgotten. Further, they believe that victims of traumatic memory are more apt to suffer from hypermnesia of the abuse than amnesia. These are the grounds upon which defense experts for court cases of CSA most often rely. (Read & Lindsay, 1994, 1997; Wakefield & Underwager, 1994) Since perinatal memory has never been at issue in the courts false memory is of minor importance to my discussion. It is reviewed here to acknowledge that it does occur in any type of altered states treatment. In an effort to demonstrate the possibilities of psychotherapists implanting false memories several laboratory experiments have been conducted by false memory advocates. The following study is an example.

Loftus (1992) conducted a study testing possibilities of false memory implantation. Participants (n = 24, 18 - 24 years) were asked to recall events occurring at about the age of 5 years that were supposedly described by a close relative. Three of the events were true and one was a false event about getting lost in a department store, shopping mall, or other public place. The subjects completed a short story about each of the events. If they could not remember the event, they were instructed to say so rather than compose a story about it.

Interviews held 1-2 weeks later revealed that participants remembered 68% of the true and 25% of the false events. The conclusion made by Loftus (1992), Loftus and Pickrell (1995), and others conducting

similar studies (Devitt, 1995; Pezdek, 1995), was that it is possible to implant false memories. The implication suggested by Loftus (1992) and Loftus and Pickrell (1995) is that if false memories can be implanted in the laboratory, it follows that they could be implanted by therapists in psychotherapy. Olio and Cornell (1994) broaden the perspective of these conclusions, however, by pointing out that there is no scientific evidence for implanting memories of the sort that is radically different from the individual's normal experience, such as, memories for traumatic CSA in someone who has never been abused, or perhaps, memories of a Cesarean birth experience where a vaginal delivery occurred.

Next is an anecdote given as an example of confabulation. It is a popular narrative that appears in the literature in various forms. One time the setting is Viet Nam with pentothal, the next time it might be WW II. or Korea with hypnosis. Brandon et al. (1998) wrote:

One of us (S.B.) was asked to see an otherwise healthy middle-aged man who presented to a neurology unit with severe pain and 'locking' of his back. Extensive investigation failed to produce an explanation and a psychiatric view was sought. The man denied any current problems and asserted that his job and marriage were unusually trouble-free. He was somewhat evasive about his earlier history and claimed to have a memory gap of several years.

Pentothal abreaction was attempted and was "dramatically successful" in that he recounted a period of sustained terror as he and his small Royal Air Force wireless section retreated in Burma and found themselves behind the Japanese lines. He was on solitary guard duty as they continued to move towards the British lines when he dropped off into an exhausted sleep. He suddenly awoke behind a bush to see all of his companions being bayoneted by the Japanese. He tried to cry out but had no voice and when he tried to stand up his back locked. Subsequently, he wandered in the jungle until found by a patrol and was evacuated to India.

This provided an adequate psychopathology, including survivor guilt. Unfortunately, when this explanation

was offered to his wife she pointed out that he had never served in the Royal Air Force. He had enlisted in the army but was discharged as unsuitable during his basic training. He had never been out of England. (p. 300)

Unfortunately, the authors did not inform us as to whether the patient's abreaction had an effect on his back problem. For as Freud believed, the veracity of the abreacted memory is not as important as its healing effect (Freud, 1893/1974). Their point is clear, however, in that memory can be complete fiction arising of unknown origins.

Hypnosis

Though the word "hypnosis" merely means "sleep" in Greek, it can carry connotations of black magic or of someone with untoward powers. In actuality, hypnosis, and its derivatives, guided imagery and birth regression, are forms of mental relaxation during which suggestions offered may or may not be followed. While many believe that a hypnotist can exhibit incredible powers over a subject, this notion is false. In fact, no one can be hypnotized without their consent (Eslinger, 1998). The literature is replete with both anecdotes and veridical studies exhibiting the positive and negative aspects of hypnosis. It is at once misleading and revelatory. Which, incidentally, is true of all the techniques used for pre- and perinatal recall - that is, altered states; sometimes they produce the desired results and sometimes not.

Hypnosis is often regarded as leading, suggestive, and resulting in the fabrication, distortion, or modification of memories (Brandon et al., 1998). Difficulties may exist in determining whether the subject is manipulating the hypnotist or therapist into believing she/he is in a hypnotic trance when in fact this is not the case. Further, a more intense transference reaction can be expected from the hypnotherapy client which may lead to greater confabulation or suggestibility. Hypnotic recall is thought by many to increase the confidence of the individual having the memory, while reducing its reliability (Kihlstrom, 1997; Lindsay & Read, 1994, 1997; McConkey & Sheehan, 1995). At times hypnotic technique has been determined to be so unreliable as a

means of eliciting memories of past events that information gathered under its influence has been deemed inadmissible as legal testimony. However, cases of memories retrieved with hypnosis used in adjudicating court cases are well-documented in the literature (Mutter, 1990; Perry, 1997; Tayloe, 1995).

While acknowledging that hypnotically connecting to the unconscious does not insure an infallible source of information, Hammond (1997) feels that much of the research used by the American Medical Association, Council on Scientific Affairs (1985) suggesting that hypnosis is inherently biasing (Dywan, 1988; Dywan & Bowers, 1983; Wagstaff & Maguire, 1983; Whitehouse, Dinges, Orne, & Orne, 1991; Zelig & Beidleman, 1981) was "...predestined to produce these outcomes by the inherently flawed nature of the research designs" (p. 363). He is referring to the use in this research of the "ideomotor signaling technique" (LeCron, 1963), where the subject is instructed to allow one finger to involuntarily lift if the answer is "no," two fingers for "yes," and three for "I don't know" or "I don't want to answer." Hammond believes that recent changes in the technique, that is, eliminating the subjects' option to answer "I don't know" or "I don't want to answer" forces them to answer "yes" or "no," thus increasing the likelihood of guessing, and guessing wrong. Loftus and Ketcham (1991) agree with Hammond and have condemned this practice as dangerous and potentially iatrogenic.

As a tool that has allowed the production of impressive veridical studies, hypnosis has been a friend to pre- and perinatal psychology. I will present the following three studies of hypnotic age regression by way of a sampling. First is a regression to infancy by Raikov (1980). The premises of this study have been challenged by Kihlstrom (1997). Next is Cheek's (1974, 1986) replication of musculo-skeletal birth imprints in age regressed adults. Finally, Chamberlain's (1986) study of mother and child pairs. Although the hypnotists cannot explain the mechanism involved in their experiments they do attest that it is a mechanism of memory.

Kihlstrom (1997), on the other hand, has determined that age regression is, "...an imaginative reconstruction of childhood, not a reversion to the genuine article" (p. 1730). He adds, "There may be

some memory enhancement produced by hypnotic age regression, but age regression is first and foremost a product of the imagination, and any accurate memory produced is likely to be blended with a great deal of false recall" (p. 1730). Brandon et al. (1998) concur with Kihlstrom, "Accounts are at times so fantastic that they are beyond belief and there is no evidence of the efficacy of this technique" (p. 301). These studies provide some of the missing evidence.

Raikov (1980) described the Babinski reflex as an outward, toe-fanning reaction seen only in newborn infants when the bottom of their foot is stroked. With greater brain maturity, the Babinski reflex is replaced by a curling under of the toes. Since the Babinski reflex is never seen in healthy adults, it is commonly used to diagnose neural impairment such as stroke. He hypnotized 10 highly hypnotizable men and women, ages 19 to 29 years, to the state of early infancy. The depth of their hypnotizability was determined by the following criteria: complete amnesia for the hypnotic experience and an adequate form of behavior corresponding to the suggested age of regression. When regressed to a verbal developmental level, each subject could converse with someone present in the regressed scene without paying attention to suggestions from the hypnotist.

The developmental stage of early infancy was chosen because it was felt that newborn movements would be most instinctual and automatic and therefore the most difficult to deliberately reproduce. The seven criteria of the newborn level were not determined until after the regression because, "...the hypnotist and the neuropathologists did not know at all precisely what neurological reactions should take place in the newborn" (Raikov, 1980, p.159).

The regression was observed, photographed, and video recorded. Attempts were unsuccessfully made to get the subjects to answer commands such as to open their eyes and to tell their ages. Also an attempt to physically force their eyes to open was unsuccessful. Sucking and grasping reflexes were observed both spontaneously and responding to touch. Newborn "cries" without tears and Babinski reflexes were observed. The uncoordinated movements of the eyeballs endured throughout the entire course of the suggested infancy. Material obtained by one of the neurologists and compared to

the photographs and videos of the age regressed adults confirmed accurate newborn reflexive behavior. From this information, the following seven criteria were distinguished:

- Babinski reflex.
- Uncoordinated eye movements.
- A sucking reflex.
- A grasping reflex.
- "Infant's" cry without tears.
- The "infant's" movements of the extremities.
- The infant's bending reflex of the foot.

The Babinski-like reflex occurred for 5 of the 10 subjects. Uncoordinated eye movements occurred in all subjects as did the spontaneous sucking reflex. The grasping reflex occurred in 4 of the 10, movements of the extremities in 4, and the infant cry with no tears in 5. The foot-bending reflex occurred in 6 of the 10 subjects. No subjects showed fewer than 2 of the 10 criteria, and 1 subject showed all of them. Raikov (1980) drew the following conclusions:

1. The reproduction under hypnosis of the components of infancy and early childhood is in a certain degree possible.

2. The suggestion of age regression in adult subjects of the deepest level of somnambulism is not acting but a reproduction of suggested states under a sufficiently deep change in the consciousness of the hypnotized.

3. The reproduction of the unconscious state of infancy under hypnosis in adult subjects to a certain extent objectifies the hypnotic state as such, and emphasizes its significance for psychological investigations and psychotherapy. (p. 162)

Despite the demonstration of phenomena such as the Babinski reflex and uncoordinated eye movements in Raikov's (1980) study, Kihlstrom insists:

...studies employing a wide variety of experimental paradigms, including the Babinski reflex, various illusions which show developmental trends, and a host of tasks derived from the developmental theories of Heinz Werner and Jean Piaget (not to mention psychoanalysis), have yielded nothing by way of

replicable evidence of ablation or reinstatement. (p. 1730)

The term “ablation” in hypnosis refers to the complete loss of access to normal cognitive functioning in an age regressed individual. This means, for example, that an adult subject regressed to a pre-verbal level of development should not simultaneously be able to listen and respond to the commands of the hypnotist as that subject should not be able to comprehend the language. “Reinstatement” is closely related to ablation and indicates the return to an earlier cognitive and emotional developmental period. An example of this would be a child who could perform concrete operations hypnotized to the level of pre-operational thought should be completely at the latter level. Based on the failure to achieve these hypothesized mental states Kihlstrom dismisses memory demonstrations such as Raikov’s (1980) as the “imaginative reconstruction of childhood” (p. 1730). No value is attributed, not even to the remarkable phenomena of uncoordinated eye movements.

Raikov (1980) insists, however, that all of the infantile behavior taken together, the uncoordinated movements of the eyeballs, and the Babinski-like, sucking, and grasping reflexes, “...cannot reduce these phenomena to the imagination alone” (p. 161). Further, while Raikov acknowledges that an ablation probably did not occur, he suggests that actual infantile memories were accessed and “...there is some inhibition of later memories and the self-assessment of the adult person, instead of an actual ablation. Hence, memories registered and stored in the pre-verbal period of childhood become available” (p. 113).

I have not found critiques negating the results of the next two studies. The authors are well-known and well-published. The first, Cheek (1974, 1986), demonstrates the type of memory known as “imprinting” discovered by Lorenz (1935). Studies of newly hatched birds revealed that life-long memories are retained of whomever or whatever the birds happen to bond with during the first day or two after birth.

The late David Cheek (1974), an obstetrician and hypnotist, showed that adults maintain imprints or cellular memories, "tissue memories" of their births.

At first he was skeptical of the idea of birth memories due to his belief that a newborn's central nervous system was too immature to record them. Over the years, however, he had witnessed some 500 live births and discovered that newborns enact identical head and shoulder movements, for vertex, breech, and Cesarean section deliveries. He recorded these movements for later use in this study.

As an example of the complexity of the sequential movements and postures of birth, Cheek described the fetal postural changes for one presentation, the right occiput anterior presentation (ROA), as follows. When the baby's head enters the maternal pelvis, its back faces the mother's right abdomen, the head is flexed slightly toward the chest, allowing the crown of the head to form a dilating wedge for the cervix. While the baby's head turns as though looking toward its right shoulder to permit the greatest diameter of the head to enter the greatest, anterior-posterior diameter of the mother's pelvis (the baby's face is looking at the mother's sacrum), descent into the pelvis occurs. Simultaneously, the baby's shoulders are entering the pelvis in a diagonal fashion from the right side of the mother's sacrum to the midpoint of the left pelvic inlet. Then, as delivery approaches, the curve of the mother's sacrum and coccyx force the baby's head to extend or look upward. After delivery, the baby's head returns to its normal right angle in relation to the plane of her shoulders. The baby's back is then on the mother's right (Cheek, 1974).

Of the 500 births he had observed, Cheek (1974/1986) performed the delivery of four babies. He recorded for the hospital record the sequential postures and movements for each baby but did not look at these notes again until after each subject completed a hypnotic regression. When the four children reached at least the age of 16 they were hypnotized to their births. The subjects for each case accurately reproduced the recorded musculo-skeletal movements for their births. No postural changes were noted in regressions of subjects born by Cesarean section. Cheek's (1974/1986) conclusion was that imprinted memories of birth remain imprinted and accessible under hypnosis, for life.

A concern of this researcher regarding Cheek's (1974/1986) classic study is that Dr. Cheek was not

"blinded" to the birth records when they were written. More compelling results might have been obtained had Cheek not witnessed the births, but rather validated the birth movements of newborns recorded by other physicians. I did not find the issue of "non-blindedness" in this experiment addressed by Cheek or anyone in the literature.

Chamberlain (1986) discovered that veridical memories could be revived from before, during, and after birth. He recruited 10 people between the ages of 9 and 23 who had no conscious memories of their births, and their mothers, between the ages of 32 and 46, who had never discussed the children's births with them. Each pair served as its own control with the mother's narrative serving as a standard of reliability for the child's report. He matched the narratives of the perinatal experiences of the children with their mothers' recollections, obtained separately while under hypnosis. The majority of details remembered by the pairs coincided, notwithstanding the differing perspectives of infants and adults.

For example, the mother in pair #1 said that her daughter was born fast and that the cord had to be cut off her neck. The daughter of that pair stated, "I feel hands touching my neck taking something off." In pair #6, Mother says, "I pick her up and smell her...I look at her toes and say, 'O God! She has deformed toes!'" Child exclaims, "She's smelling me! And she asked the nurse why my toes were so funny..." (Chamberlain, 1986, p. 92). Of the 10 pairs, Chamberlain (1986) recounts 137 "dovetails" or agreements on details and 9 contradictions in their narratives. He has concluded that newborns are more physically, mentally, and emotionally conscious than anything heretofore determined by developmental psychology (pp. 93-94).

Inducement into age (birth) regression using guided imagery is another form of hypnosis. The subject(s) are guided to relax and imagine moving back through time to their birth or even to their conception. The therapist might suggest that they are floating in the ocean, which then becomes the amniotic fluid and so on. Regressions often begin in this way, leading the subject deeper into relaxation and trance. The idea of the water in the ocean being reminiscent of the salty water of the womb is an example of "state dependent

learning" (Cortright, 1997). That is, jogging memories of birth or prenatal life is more likely to happen if the individual can replicate a sense of "wombness." Other props and inducements are sometimes used to produce altered states reminiscent of birth and before birth. Such props may include: wrapping subjects tightly in blankets or between mattresses; listening to taped music with watery sounds and heartbeats; curling participants bodies into a tire hanging from a rope; hammocks, and many more. Orr and Ray (1977) used hot tubs at a certain temperature to induce a womb-like state.

Grof (1985, 1988) has an extensive pre- and perinatal art collection which he displays along with a slide show on the evening before many of his holotropic workshops. This along with his lecture regarding the perinatal realms are techniques that seem to "loosen" very early memories. Grof (1999) points out that most Westerners are not familiar with non-ordinary states and have a narrow concept of the psyche. He adds that current psychiatric thought often denounces altered states therapy including concepts of the perinatal as pathological indications of psychosis. Therefore, he discusses the spectrum of possible experiences to counteract this type of programming. (Personal communication, February 13, 1999.)

The point here is that while all of these techniques and all other birth memory therapies are suggestive and probably produce a great deal of false memory and general memory distortion, they seem to be the only methods that give rise to authentic pre- and perinatal memory.

The Work of Stanislav Grof

Grof (1972, 1973, 1975, 1979, 1985) a psychoanalytically trained psychiatrist from Czechoslovakia, has made a tremendous contribution to pre-and perinatal psychology with original research dating back 30 years. He tells of his struggles in breaking with traditional psychoanalytic practice in order to integrate the new discoveries his LSD research was uncovering. As a result of this extensive psychotherapeutic research he believes that LSD, or in its absence, holotropic breathwork, can assist people in manifesting non-ordinary states of consciousness, giving access and resolution to biographical trauma,

to the pre- and perinatal realms of consciousness and birth, and to the transpersonal realms.

Thousands of case studies of subjects experiencing high doses of LSD led him to the conclusion that his patients were not only reexperiencing their biographical histories and especially the traumas and tragedies therein, but they were reliving their births. Grof felt that birth would be the final level of consciousness to resolve, but his subjects were not stopping. They were having what seemed to be "past-life" and other extraordinary experiences, which he called "transpersonal." Grof went on to formulate a model of consciousness for conducting psychotherapy using LSD. The three-tiered construct contains (a) the psychodynamic or biographical, (b) the pre- and perinatal, and (c) the transpersonal levels.

The psychodynamic level involves the remembrance or reexperience of the significant events and traumas of a person's life. Clear recollections of the first days or weeks of life often occur. Physical trauma, such as disease, accidents, surgeries, or childbirth, may be relived in photographic detail (Grof, 1985, p. 37). This level is usually confined to normal ego limitations. That is, the person would not feel as though they had left their body, or that they were living outside of normal ego states or time or space dimensions.

The perinatal, is the core of Grof's theory, connecting the psychodynamic with the transpersonal, the individual with the collective unconscious. He calls it "Encounter with Birth and Death" and likens the experience to "...participation in ancient temple mysteries, initiation rites, or aboriginal rites of passage" (Grof, 1985, p. 100). So profound is the existential crisis that takes place during the perinatal segment, that the individual calls into question the meaning of life, their basic values, and life strategies. Though the entire perinatal experience cannot be reduced to a reliving of biological birth, the birth trauma represents a core focus. Reliving birth can manifest as,...agonizing pain with facial contortions, gasping for breath and discharging enormous amounts of muscular tension in tremors, twitches, violent shaking and complex twisting movements.... the face may turn dark purple or dead pale...sweating may be profuse, and nausea with projectile vomiting is a frequent occurrence. (Grof, 1980, p. 72)

The “basic perinatal matrices” (BPM) developed by Grof (1973) correlate with established clinical stages of childbirth (p. 27). The BPMs are as follows:

1. Perinatal Matrix I (Primal Union With Mother). This matrix is associated with prenatal life before the onset of labor. Undisturbed or “good womb” experience can be relived concretely or as an ecstatic spiritual state. Likewise, disturbed or “bad womb” experience can be relived biologically and as various forms of spiritual crises (Grof, 1973, p. 29). The subject at this stage has not yet begun to feel the pressure of contractions. They are experiencing fetal existence prior to the onset of labor.

2. Perinatal Matrix II (Antagonism With Mother). This matrix relates to the first clinical stage of delivery. The prenate feels “uterine contractions in a closed system.” That is, the cervix has not yet begun to dilate, but contractions are relentless. The biological experience of this matrix is a feeling of being hopelessly trapped. The symbolic counterpart is the experience of “no exit” or hell. Per Grof, one feels “...indescribable suffering and cannot see the way out of this situation, neither in time, nor in space.” The world is viewed, “as an apocalyptic place, full of wars, epidemics and horrors, and human life appears as totally meaningless and absurd” (Grof, 1973, p. 30). Trapped in the “no exit” situation, the individual experiences human existence as meaningless, but nonetheless has a strong drive to find meaning (Grof, 1975, p. 120). It is a “no win” dilemma.

3. Perinatal Matrix III (Synergism with Mother). This matrix is related to the second stage of clinical labor, when the cervix is dilated and the baby is pushed through the vaginal canal. According to Grof, as it is relived in a non-ordinary state, the experience of BPM III is either the actual biological experience of birth, or it is experienced psychospiritually as “a titanic fight, the Death-Rebirth Struggle” (Grof, 1973, p. 30). “The frail head of the child is wedged into the narrow pelvic opening by the power of uterine contractions that oscillate between 50 and 100 pounds” (Grof, 1985,

p. 116). This can create hallucinations depicting battles and struggles for survival of enormous proportions, for example: “volcanoes, electrical storms, earthquakes, tidal waves or tornadoes...” (Grof, 1985, p. 116).

4. Perinatal Matrix IV (Separation From Mother). This matrix relates to the third clinical stage of delivery, when the baby is finally separated from mother and the umbilical cord is severed. Some subjects relive this physically. The early cutting of the cord can be a shocking and painful experience, as much of the blood and oxygen that allow survival for the infant are still in the placenta. However, most people relive this stage with a psychospiritual encounter, as Grof describes, an “enormous expansion of space” and “visions of radiant light and beautiful colors.” According to Grof, “The symbolism associated with this experience usually is religious or mythological, and involves elements of liberation, salvation, redemption, or victory over a powerful enemy” (Grof, 1973, p. 31).

The following is an anecdotal report from one of Grof’s (1988) breathwork sessions involving the reexperience of birth. Depictions of holotropic breathwork at times seem nearly indistinguishable from LSD session reports. This striking example involves a woman named Gladys. She had been suffering from intense anxiety and depression. Asked to lie down in the center of the group and to surrender to the music, she soon began to exhibit “violent tremors, loud noises” and battles with “invisible enemies.”

The second part of her journey found her screaming and chanting in an unknown language. It turned out that Gladys herself did not recognize the “Ladino” language she was speaking, which is a combination of medieval Spanish and Hebrew. The literal translation of the chant is, “I am suffering and I will always suffer. I am crying and I will always cry. I am praying and I will always pray.” Afterward, Gladys was able to relax into a state of ecstasy lasting nearly an hour. She identified the session as the reexperience of her birth (Grof, 1988, p. 169).

When a participant completes the perinatal or birth/death cycle, they ostensibly move on to the

transpersonal level. A transpersonal experience, as defined by Grof, is one that exceeds normal ego limitations and the boundaries of time and space. It can include experiences from the perinatal. Among the many categories of possible transpersonal experiences to be accessed in an altered state are: the phylogenetic (the reliving of the lives of plants or animals), past-life incarnation, space travel, archetypal experiences, and extraplanetary consciousness (Grof, 1975, p. 156). Included by Grof (1972) in the transpersonal category are experiences of extrasensory perception, such as, precognition, clairvoyance, out-of-body phenomena, traveling clairvoyance, space travels and telepathy.
Sutich (1969) provides a broader definition for the transpersonal as:
The emerging Transpersonal Psychology ("fourth force") is concerned specifically with the empirical, scientific study of, and responsible implementation of the findings relevant to becoming, individual and species-wide meta-needs, ultimate values, unitive consciousness, peak experiences, B-values, ecstasy, mystical experience, awe, being, self-actualization, essence, bliss, wonder, ultimate meaning, transcendence of the self, spirit, oneness, cosmic awareness, individual and species-wide synergy, maximal interpersonal encounter, sacralization of everyday life, transcendental phenomena, cosmic self-humor and playfulness; maximal sensory awareness, responsiveness and expression; and related concepts, experiences and activities. (p. 16)

A case history demonstrates a phylogenetic, transpersonal experience of one of Grof's (1975) LSD subjects. A woman, Renata, "became" a large reptile that was extinct millions of years before. She saw her therapist as a male reptile of the same species. He appeared to have a large, colorful field of scales on the side of his head which radiated powerful sexual vibrations and made Renata quite passionate (p. 173). Afterward, Grof (1975) was able to validate parts of this experience. He consulted with a friend studied in paleontology and zoology, who established that certain species of ancient reptiles display vivid color patterns on the head when engaging in mating behavior (p. 173).

Another important part of Grof's (1985) map of the unconscious is the COEX system or "systems of condensed experience" (p. 97). These are principles governing the dynamics of the individual unconscious or organizing principles. Grof (1985) writes:

A COEX system is a dynamic constellation of memories (and associated fantasy material) from different periods of the individual's life, with the common denominator of a strong emotional charge of the same quality, intense physical sensation of the same kind, or the fact that they share some other important elements...the systems of condensed experience represent a general principle operating on all the levels of the psyche, rather than being limited to the biographical domain...It is not uncommon for a dynamic constellation to comprise material from several biographical periods, from biological birth, and from certain areas of the transpersonal realm, such as memories of a past incarnation, animal identification, and mythological sequences. (p. 97) ...the connecting link is the same quality of emotions or physical sensations, and/or similarity of circumstances. (p. 101)

According to the nature of the emotional charge, Grof (1985) distinguishes "negative" unconscious governing systems which consist of: negative COEX systems, BPM II, BPM III, negative aspects of BPM I, and negative transpersonal matrices; from "positive" systems: positive COEX systems, BPM IV, positive aspects of BPM I, and positive transpersonal matrices. Through deep experiential work the individual is helped to "transmodulate" or to experience an "inner dynamic shift" from the negative system to the positive, which then manifests in a dramatic experiential shift in normal, waking life. (p. 350)

While acknowledging that psychedelic drugs and other non-ordinary states of consciousness are not without their drawbacks, Cortright (1997) supports Grof and other proponents of their therapeutic usage by pointing out that they can reliably produce transpersonal and spiritual experiences of profound intensity and power. According to Cortright (1997):

It is not that psychedelics magically invoke God. Rather it seems that if the set and setting support

it, the psychedelic compounds somehow act to thin or lift the normally thick veil between normal consciousness and the spiritual dimension, allowing the spiritual dimension to be revealed. (p. 181)

While not of a pre- or perinatal nature, the following study demonstrates the sort of spiritual awakenings that might be brought about by a psychedelic experience. On Good Friday, 1962, Pahnke (1963) gave some capsules to 20 Protestant divinity students before a church service. Half of the capsules contained psilocybin and the other half a placebo. The majority of the psilocybin group reported having had experiences that were indistinguishable from classical mystical experiences. Doblin (1991) conducted a 25 year follow-up study with Pahnke's experimental divinity students. He summed up the feelings of the psilocybin subjects this way, that their Good Friday experience had elements of "...a genuine mystical nature and characterized it as one of the high points of their spiritual life" (p. 13).

Cortright (1997) not only supports psychotherapy with altered states of consciousness in general and psychedelics in particular, but he recognizes their limitations and drawbacks as well. Using the idea of rats that have received LSD, cocaine, or alcohol to demonstrate "state-dependent learning," he explains that anything learned by the altered animals would be forgotten by them when sober. If the animals were again put under the influence of the mind altering substance(s), their prior gleanings would return. Cortright believes that psychotherapy conducted with subjects in non-ordinary states of consciousness frequently will not carry over and be useful under normal states of consciousness. Regarding this, Cortright (1997) writes:

So even though there may be a depth of experience and insight during a psychedelic session which seems cosmic and life-changing at the time, upon returning to normal consciousness the experience or insight can seem ethereal, hard to remember or put into practice, and with time may fade away altogether. (p. 201)

Freud (1893), discarding the use of hypnosis in favor of psychoanalysis felt that since hypnosis bypasses the ego and its mechanisms of defense, it was evading

the real work of psychotherapy. Similarly, Cortright (1997) feels that since much of the work of altered states therapy is done by bypassing the ego and the defense mechanisms, its usefulness upon return to ordinary consciousness is dubious. As a remedy to this dilemma, he recommends using low dosages of psychedelics with careful processing at the session's end and in follow-up sessions.

One criticism derived from the object relations and self psychology schools of thought is that sporadic altered states therapy sessions are no substitute for the therapeutic relationship. That is, part of the healing reconstruction of a damaged self-image involves the slow, consistent, long-term relationship with a therapist. Periodic altered states encounters cannot provide a structure sufficient for the rebuilding of the personality (Cortright, 1997).

It was once believed that altered states were the equivalent in psychology of what microscopes are to biology, in that they were thought to give an expanded, magnified view of the consciousness. Cortright (1997) asserts that this notion is untrue and that in reality non-ordinary states produce "skewed maps of consciousness" (p. 203). About psychedelics in particular and altered states in general he says they are "...a kind of lens that obscures as well as reveals, and as yet there is no universal agreement about the significance of some of its views of human consciousness" (p. 203).

In his analysis of the weaknesses of non-ordinary states of consciousness Cortright (1997) apparently misses the benefit of the catharsis and decathexis that can occur when breathwork or various chemical substances return the participant to earlier realms of consciousness. He focuses on the "learning" or insight one might glean and then forget from such an experience, and fails to address the resulting psychological gains from incredible releases of mental and emotional energy. As these releases occur, growth becomes apparent in ordinary consciousness. Further the individual finds that deeper and deeper levels of emotion and unresolved trauma become available for resolution in the waking state.

Following the criminalization of LSD in the USA in 1968, Grof continued his research by developing the technique of holotropic breathwork. "Pneumocatharsis"

or “intense breathing” combined with evocative music and bodywork is utilized with large groups of participants, in an effort to access altered states of consciousness. Grof (1988) traces these methods to the “ancient Indian science of breath, or pranayama” (p. 170).

The workshops generally consist of a lecture review of Grof’s perspective, the BPMs, and his map of consciousness. An art exhibit and slide show are the main display with vivid examples of pre- and perinatal art. Breathwork begins the next morning with the client group being divided in half, the “breathers” and the “sitters." They switch roles the following day, allowing everyone to have a turn at breathwork and at attending a client who is “breathing.” Clients are then encouraged to use art paper and colored pencils provided to draw mandalas expressive of their experience.

The following study is a comparison between the breathwork of Grof and that of Gay and Kathlyn Hendricks (1987). The study was conducted and summarized as a doctoral dissertation (Smith, 1988).

A Comparison of Grof’s With Hendricks’ Breathwork

A “bodymind perspective” for conducting pre-and perinatal psychotherapy with adults was presented by Hendricks and Hendricks (1987). Given individual emotional responses when using phrases reminiscent of birth, such as, “Sounds like you’re feeling stuck” or “It’ll feel really good when you pull yourself out of this,” may help to identify whether the current psychological issue is in the perinatal realm. A combination of Reichian-style bodywork, acupressure, massage, finger pressure on tense muscles, and the following Hendricks’ specialties make up the therapy.

- Radiance movement meditation, “a direct, attentive, moving dialogue” with the “inner self” helps to reveal the type of pattern the client developed while trying to be born.

- Radiance breathwork guides the client into a deep breathing exercise designed to evoke psychological material.

- Radiance prenatal process is conducted in a hot tub or pool, heated to the temperature of the womb. The client is regressed to a prenatal time and helped to

clear any troublesome feelings that may remain from that time. A transformation of negative self-esteem to a feeling of being "loved and wanted" is encouraged (pp. 235-6).

Hendricks' breathwork sessions are similar to Grof's in many respects. That is, they are held in large rooms with evocative music, dim lighting, and padding on the floor. Contrary to Grof, the Hendricks' format does not include a lecture and demonstration of pre- and perinatal art. Further, the Hendricks do not focus on the "BPMs" (basic perinatal matrices) of Grofian theory. Unlike Grof, they do not include a "sitter," but like Grof, attendants/bodyworkers are available. Grof is less specific than the Hendricks in how to conduct the actual breathing. The Hendricks instruct participants to lie on their backs, either flat or with knees up. Then they are to set any intentions or goals for themselves, consider fears they have, and ask any final questions. Breathers are to relax their jaws, open their throats, and breathe in and out through the mouth. The mouth should be open wide enough to get two fingers between the upper and lower front teeth. They should say a loud and long, "aaah haaa" as they begin breathing.

According to Smith (1988) Hendricks' workshop style is more relaxed than Grof's; the music is designed to soothe. On the other hand, and by virtue of its wild or savage flare, a holotropic musical selection tends to evoke biographical and perinatal memory, or archetypal and transpersonal experience. Hendricks' style is loving acceptance, gentle stimulation, and the allowance of whatever comes up. The Grofian theme tends to be rougher, even upsetting. Variations in bodywork styles reflects basic philosophical differences. That is the Hendricks aim to comfort and help process, whereas Grof's bodywork is designed to intensify the experience. Lastly, Grof's workshops are longer sessions, as much as 4 hours as contrasted to Hendricks' 50 to 75 minute sessions (Smith, 1988, p. 117).

Smith (1988) conducted the study comparing these two breathwork approaches to measure their potential to evoke transpersonal experience. While adhering closely to Grof's and the Hendricks' formats, one major difference between this study and the actual workshops

was that Grof's standard, pre-workshop lecture and art show of the pre-and perinatal realm was not given. In spite of this considerable distinction, the group receiving holotropic breathwork in Smith's study scored significantly higher on scales measuring BPM imagery than did those participating in the Radiance Breathwork session.

The Peak Experience Profile (PEP), a self-report test, was used to measure the frequency and nature of transpersonal experiences prior to and after the Grof and Hendricks breathwork sessions. A control group was given no treatment until after the data were collected. The control group was given the PEP twice over a 2-week period before its members participated in a breathwork session. Included in the PEP are two parts, one measuring mystical or peak experiences, and the other measuring Grof's experiential categories, that is, the BPMs (basic perinatal matrices).

The first half of the PEP revealed no significant differences between the Grof- and Hendricks-style treatment groups in terms of mystical or peak experience. The second part of the PEP, measuring Grof (BPM) experiences, was significantly higher for the Grof treatment group. Smith (1988) explains this by noting that the profiles indicated the participants in the Grof treatment group to be higher on six of the subscales at the time of the pretest.

The most important finding here is that these breathwork sessions are valuable for evoking transpersonal or non-ordinary states of consciousness. According to Smith (1988), when appropriate screening and facilitation is maintained, the work is a safe and reliable approach to exploring transpersonal states, and for accessing unconscious psychological material. He emphasizes that it is a "safe and legitimate alternative to taking psychedelic drugs" (p. vii). This researcher would add that breathwork is a legal avenue to an altered state of consciousness which can encourage insight and possibly provide access to pre- and perinatal memory.

Grof has been instrumental in making non-ordinary states of consciousness accessible to the average person. This is a boon to those who are uncomfortable with taking drugs or breaking the law by providing an access to spiritual realms in a heretofore unheard of manner. Further, he has lent a measure of

respectability to the importance of pre- and perinatal psychology to mental and physical health and devised an ingenious model of organization for very early consciousness. The studies I have found evaluating the psychological and spiritual outcomes of holotropic breathwork or LSD psychotherapy applaud Grof's model and methods (Ferlemann, 1972; Pressman, 1993; Tarnas, 1976). Books, dissertations, and articles written about his research focus in large measure on his three-tiered model, and may expand on his concepts (Bache, 1998; Tarnas, 1966, 1991), but generally find little with which to disagree (Bache, 1998; Holmes, Morris, Clance, & Putney, 1996; Pressman, 1993; Smith, 1988; Tarnas, 1976, 1991). A striking contradiction to this rule is found in the work of Arthur Janov (1970; 1976; 1983; 1991).

Primal Therapy

Janov (1970) made his debut with The Primal Scream. In this book he taught how to conduct "primals." These are extended psychotherapy sessions, some for a week or longer, by leaving the client in seclusion, and removing common distractions such as radio, television, snacks, books, et cetera. In this way ostensibly, the individual has no way of blocking repressed memories and emotions from entering consciousness. Then, with the therapist's promptings, the repressed material, ever seeking expression, makes its way out of the subconscious. Janov stumbled upon this technique while witnessing some of his clients spontaneously scream as he employed a Gestalt-like technique of having them call out to their parents, "Mommy! Daddy! Mommy! Daddy!" (Janov, 1970, p. 9).

Primal therapy is basically psychodynamic in that it underscores the importance of early childhood experience to the resolution of neurotic adult conditions. Janov (1970, 1983) believes that every child has basic "primal" needs, such as, love, security, food, warmth, protection, stimulation, understanding, et cetera. When these needs go unmet for any length of time, the child experiences "primal pain," such as, fear, chronic insecurity, helplessness, or loneliness. About this Janov writes, "These primal needs are the central reality of the infant. The neurotic process begins when these needs

go unmet for any length of time" (p. 22).

According to Janov (1970, 1983) unmet primal needs eventually turn into the sense of deprivation which forces the child to shut down feelings in order to survive. These "shut down" pains are expressed in the form of neurosis as a split occurs and a "false self" develops to suppress the "real self." Janov describes this split as a disconnection of thought from feeling, memory from affect, mind from body, and present from past. About this Janov (1970) writes,

Primal Therapy regards neurosis as the synthesis of two selves, or systems in conflict. It is the function of the unreal self to suppress the real one, but because real needs cannot be eradicated, the conflict is unending. (p. 35)

The process of primal therapy aims at the reintegration of the real and the false selves through total mind/body experiences. Maturation and healing occurs as feelings from the past are relived in the present.

Like Grof, Janov came to believe in birth recall as he watched his clients writhing in pain, unable to breathe, with a significant elevation of all the vital signs. About a birth primal Janov (1983) writes, "...body temperature rose by 3 degrees, pulse and blood pressure doubled, and brain wave amplitudes skyrocketed... They turned colors of red and blue as the early imprint took over (p, 18)." After considerable resolution of the pain the primalers (people engaged in primal therapy) would become certain of having reexperienced their births. "Then," says Janov, "...the deepest insights flowed, with an effortlessness, depth and profundity that could not be faked" (p. 9). Janov (1983) depicts his belated convictions about birth and "birth primaling" (using primal therapy to reexperience birth). Through colorful, detailed case histories, he demonstrates the long-term effects of birth. He and his associates became aware that adult symptomatology could lead a client into a birth primal. They recognized that as a client had a symptom, such as a migraine or a seizure, a skilled primal therapist could lead them, consciously, back to the original catalyst for the feeling, often birth, and if the catharsis occurred the symptom would disappear (p. 18).

While Grof and Janov agree that reaching the perinatal realm can be the most important step in the resolution of psychological disorder and general unhappiness, their approaches are nearly opposite. Grof has traditionally taught non-ordinary states of consciousness through LSD or holotropic breathwork, but Janov denounces altered states therapies, and believes that childhood pain can only be reexperienced and resolved through normal waking consciousness. (I find it difficult to believe, though, that birth can be reexperienced through other than a non-ordinary state of mind. How can one be in an ordinary state of consciousness and be feeling the impact of birth simultaneously?) Further, while Grof enjoys a spiritual basis for consciousness Janov believes that spirituality is a way of masking pain. About Transcendental Meditation Janov (1970) writes,

> The only way I can describe meditation is to call it an anti-Primal. It involves detachment instead of connection, abnegation of self rather than feeling the self, and it believes in the necessity of mind-body split. It seems to be solipsistic in nature since nothing really exists except as a painting on a canvas. (p. 222)

Factions have formed among primal enthusiasts due to Janov's denunciation of spirituality. As a therapist and teacher, Janov does not validate his clients' spiritual experience descriptions but plays them down as being another way to avoid Primal pain. Adzema (1985) takes issue with Janov's convictions,

> Basically, I differ with Janov in that I believe that primal and meditation are congruent techniques beneath their surface differences. I believe that this is evident in the similarity of the phenomena experienced in each and in the similarity of effects each has on the personality. Their congruence is further indicated by the fact that transpersonal phenomena do seem to occur to advanced primalers, contrary to Janov's claims. (p. 88)

Adzema (1985) believes that Janov himself has been unaware of the joyful possibilities of the primal process. About a spiritual primal process, Adzema writes,

> The point being made is that the primal process of

which we speak is the same as the spiritual process. Both catharsis and calmness are natural parts of the same flow, mingling and alternating with each other, and emanating from each other, in a dialectical, sometimes in a linear way. This flow is a natural process of creation that encompasses both types of phenomena, the agonies and ecstasies of existence, and harmonizes all of reality, both internal and external, in a pattern that is unique for every individual and oriented toward one's patient unfolding in the path of exquisiteness. (p. 113)

Yassky (1979) faults primal therapy on the same grounds that Cortright (1997) criticizes altered states therapies. The primal relationship does not provide sufficient, "relationship-ing" (p. 123). That is, a consistent, enduring, reconstructive therapeutic relationship is needed for a reconstruction of the damaged self. This seems to be missing in both primal and altered states therapies.

Utilizing classic phenomenological method, Khamsi (1987) interviewed 13 co-researchers who had experienced birth feelings with primal therapy. Among the more negative feelings reported by subjects were: "feeling held back, held down, helpless, unloved, or unwanted" (p.49). When breathing was a problem for them, subjects seemed to experience a sense of danger as though they "weren't going to make it" (p. 49). When breathing was free, subjects reported feeling ecstatic and that "the world is a nurturing place" (p. 50). Among the conclusions drawn by the researcher were: birth feelings represent an important avenue of therapeutic change; birth feelings were mainly considered very beneficial, rendering "heightened insight and self-acceptance" (p.58); and "most subjects felt they were born with feelings, some sense of the self, and an ability to think" (p.55).

A study evaluating the effectiveness of primal therapy revealed that this type of cathartic psychotherapy has its benefits and limitations. Dahl and Waal (1983) had 13 primal therapy patients interviewed by independent evaluators before primal treatment, and then again after 2 years. Ten patients were determined to have had neurosis, and 3 had personality disorders according to DSM-III (Diagnostic & Statistical Manual, 3rd Edition, APA, 1981)

criteria. At the 2 year follow-up, of the 11 patients who stayed in treatment, 8 were improved on all outcome variables: (a) symptoms, (b) interpersonal relations, (c) social functioning, and (d) internal predisposition. One patient had an affective psychosis triggered by the treatment.

Conclusions drawn by Dahl and Waal are that positive results in primal therapy correlate with the psychological resources of the patient. Careful screening is advised.

Nine patients spoke positively toward primal therapy, while four had a more skeptical attitude. All the patients felt it was a potent form of therapy that induced strong emotions and bodily reactions in them. All the patients who completed treatment felt that their personality had changed and all except 1 rated primal therapy higher than their former therapies.

I agree with Dahl and Waal (1983) that primal therapy is powerful and effective, but must be used with careful screening as to the psychological strengths of its participants. Further, not everyone has a spiritual basis for life and while Janov appears not to, he appeals to those for whom his approach is comfortable. Primal therapy has spread to all parts of the USA and many other countries, and as a result, it has multiple factions representing its many variations.

Benefits of Remembering

Despite their basic differences, a confluence of opinion occurs for Janov (1983) and Grof (1973, 1975, 1979, 1985) regarding the alleviation of psychosomatic symptomatology resulting from the reliving of the pre- and perinatal. Etiology is a different matter, however, as Janov attributes most psychosomatic illness to a “shutdown” of the bodymind at birth, and Grof believes these conditions can have roots in the perinatal or as deep as past lives or other transpersonal occurrence.

The pre- and perinatal psychogenesis and ultimate mitigation or cure through its remembrance of the following conditions is noted by both Janov (1983) and Grof (1973, 1975, 1979, 1985): depression, kleptomania, pyromania, various phobias, obsessive-compulsive neuroses, suicidality, asthma, sexual

dysfunction, addiction, impulsive gambling, stammering, nail biting, ulcerative colitis, migraine headache, psoriasis, bladder and bowel control, psychosis, hyper-ambition, over-dependence or independence, and eating disorders.

Birth Psychotherapy With Infants and Children

I have included the following section to illustrate the far-reaching aspects of birth trauma resolution. Though my study is of adult co-researchers experiencing healing through the remembrance of the pre- and perinatal I feel the reader might benefit from knowing that this therapy can be applied in many ways and with people at any age.

In the late 1970s William Emerson collaborated with Frank Lake in an effort to develop Somatotropic Therapy, which contains somatic approaches to the uncovering of primal trauma. He formulated a model of "somatic-reading" wherein he could determine the client's pre- and perinatal trauma by observing posture and facial expression (Emerson, 1994, p.6).

Primal therapy for infants began in 1974 when Emerson (1987) treated a baby girl suffering from severe bronchial spasms, the result of a very difficult birth. By utilizing somatotropics, he hand-simulated "pelvic and muscular pressures" experienced by the infant during her birth. She was then able to abreact the trauma, cathart associated emotions (terror, sadness, and anger) and cure the severe bronchial spasms that had indicated her treatment (p. 61).

The earlier the trauma of birth is addressed in therapy, the better. Infants can participate in the reactivation of their birth with surprising ease and even more surprising results. The first step in Emerson's treatment of babies is to establish rapport with the baby and its parents. About this Emerson and Schorr-Kon (1994) write,

> The essential and underlying presupposition is that the babies are sentient and capable of precise communication...Frequently, release from pain occurs simultaneously with babies perceptions that they are being heard, seen, and felt, perhaps for the first time. (p. 23)

Once deep contact has been made, the therapist makes a scrutiny of baby's face, head, and body, observing postures and movements which embody the birth schema.

Parents are required to participate in the therapy and, in effect, taught to relate to their child in a clear and sensitive manner. This process often catalyzes emotional releases in the baby. Behavioral changes begin to occur toward the parents as the child abreacts the pain and trauma of birth (Emerson & Schorr-Kon, 1994).

Energetic memory is located by the therapist through "near touch." The infant leads the energetic search by responding to the therapist's touch. About this Emerson and Schorr-Kon (1994) write,

> An essential element of this work is its procedure under the control of the baby. This cannot be stressed too heavily. The baby in this process is engaged: it is informed that it will be in charge of the cathartic process, which it can stop at any time... The baby will often endure bouts of re-lived pain of some intensity and, between rests, will often guide the practitioner's hand to the areas which require work and adjustment. The skin on the head, neck or body may occasionally change color, and/or temperature, or it may swell, and these are all clear signals of the physical impact of birth trauma retained at an energetic, cellular, or tissue level in the body. (p. 25)

The late Leah LaGoy (1993a, 1993b), a therapist, teacher, and author had unique talents for doing therapy with the infant and toddler population. Working through birth trauma with play therapy and the participation of the parents, Leah used props to represent the umbilical cord, the neonate, the uterus, or placenta. The children played out their trauma, using the props provided. LaGoy's specialty was interpreting what a child's play meant, which often helped the young clients to abreact repressed emotion. She tells of child clients utilizing sand tray therapy to play out the loss of a twin, with the depiction of "scenes of floods and eggs and babies being devoured." "The threat to the remaining twin's life, as well as the deep grief from the loss of the twin, has lifelong effects, one of which can be the weakening of the parent-child bonding process" (LaGoy, 1993a, p.441; Noble, 1993).

According to LaGoy (1993b), 20 of the 22 children she treated in the course of her career had suffered

the loss of a twin in utero. To support her contention that most pregnancies originate as multiple conceptions, she refers to UCLA environmental biologist, Jared Diamond. LaGoy (1993b, p.1) writes that "...Diamond's research (1992) shows that 80% of all pregnancies originate as multiple conceptions." This was an apparent misinterpretation on LaGoy's part. While it can be implied from Diamond's (1992) research that many pregnancies begin with multiple conception, he actually did not say that. He stated the following,

Of pregnancies clearly recognized by the mother, only 15 percent end in miscarriage. However, modern hormonal tests can detect many other pregnancies that terminate within a couple of weeks, indicating a total miscarriage rate of about 50 percent rather than 15 percent. Outcomes of attempted artificial fertilizations of ova within the fallopian tubes suggest that still more embryos are lost even before implantation, adding up to a total loss rate as high as 80 percent (p.18).

The Bodynamic Style of Resolving Birth Trauma

A developmental perspective for working with pre-, peri, and postnatal material has been created and taught by Marcher, Ollars, and Bernhardt (1990). Marcher, a body psychotherapist from Denmark, conducted original research for 20 years, exploring psychomotor development, which has led to, "The Bodynamic Imprint Method of Resolving Birth Trauma." This therapy is included to demonstrate how pre- and perinatal psychotherapy can be a part of a long-term therapy. I do not wish to imply that focusing on the resolution of birth trauma can provide the resolution, for example, of a childhood history of abuse.

Psychotherapy with the Bodynamics Institute in Albany, California, is long-term therapy. Resolving birth trauma is not something that is considered necessary in every case, and it is only done within the long-term context. Determining when and if a "rebirth" is called for is part of the therapeutic process, and it is generally expected that the client will complete two to three years of bodynamic therapy prior to the application of a rebirth. The rebirth, if applied, lasts for about three hours and concludes

with the creative integration of a positive birth experience.

This theory has some unique aspects. For example, a "bodymap" is drawn as each major muscle is tested. The muscles are individually associated with varying developmental stages. As pressure is applied to a muscle the therapist determines the degree of emotional response on the part of the client and records it. In this way the clinician can identify which developmental stages were impacted most strongly in childhood and can chart the course the therapy will take. According to Marcher, Ollars, and Bernhardt (1990), "Our theory is that whatever good or bad environmental influences are happening at a given stage will be embedded in the psychomotor processes of the grown adult" (p. 289).

Routine Obstetric Interventions

A secondary aim of this study is to raise awareness of the risk inherent in routine obstetric and neonatal intervention. Phenomenological research of the remembrance of birth and before, including the current study, render outcomes pointing to the painful long- and short-term penalties often paid by individuals who have encountered this technology (Emerson, 1987, 1994, 1998; Grof, 1985; Janov, 1983; Ruch, 1988).

The typical treatment of a normal newborn in the hospital setting may be psychologically devastating. After birth they face the almost instant severing of the umbilical cord, the immediate cleansing of the respiratory pathways, perhaps a slap on the buttocks, and a drop of silver nitrate in each eye to prevent the possible infection of gonorrhea from the mother. Then the baby is quickly washed, examined, shown to mother, and hustled to the nursery. (Grof, 1985)

About the impact of this treatment on neonates Grof (1985) writes,

A child treated in this way emerges with a deeply ingrained message that the intrauterine paradise was lost once and forever, and things will never be good again. A sense of psychological defeat and a lack of confidence in confronting difficulties are engraved on the very core of his or her being (p. 255).

The critical focus of this study is that of adult co-researchers experiencing healing through the

remembrance of the pre- and perinatal. Often the healing comes from the abreaction of trauma induced by obstetrical intervention. I am not suggesting that life-saving and comfort-giving pre- and perinatal measures be abandoned. For it is well-known that the leading cause of death for women prior to the onset of modern obstetrics was childbirth. I am, however, expressing my belief that the impact these measures may be having on infants and mothers, their relationship, and life-long mental and physical health is grossly misunderstood.

With this perspective in mind, I suggest that a great deal of research be applied focusing on the improved quality of the birthing and bonding experience, and to assure the safety of obstetric and neonatal intervention. A small sample of such intervention follows. It includes material on amniocentesis, fetal heart monitoring, frequent ultrasound, circumcision, and anesthesia, and underscores the risks involved in routine obstetric technology (Verny, 1992).

Using qualitative methodology in the form of extensive questionnaires, and follow-up interviews with 27 adults, Ruch (1986) wrote The Experience of Being Born as Recalled in Adulthood, The participants utilized one or a combination of the following therapies to reexperience their births: primal therapy, past-lives therapy, Gestalt, rebirthing, hypnosis, bioenergetics, Jungian analysis, psychodrama, and Freudian analysis.

Some of the salient results of the study follow. The most important factor determining the quality of the birth experience was the mother-baby relationship. Generally, the more the relationship was disturbed by medical intervention, complications, or psychological problems, the more traumatic the birth. Second, the factor most disruptive to the birth process was anesthesia given to the mother. Most interviewees who had received medication experienced a labor that was slowed down considerably, or halted completely. Lastly, the author noted that the apparent adverse effects of medication on the mother-baby relationship at birth had, at that date, not been mentioned in the literature (Ruch, 1986), indicating that not much thought had been given to the effects the drugs were having on the fetus.

It is estimated that anesthesia is given to mothers

in 80% of all hospital births and ironically, almost no research has been published about the short- and long-term psychological affects of the drugs (Shanley, 1994). Possible life-long psychological outcomes from the use of anesthetics at birth have been observed and enumerated by Emerson (1998). They include bonding deficiencies, shock syndromes, control complexes, productivity complexes, boundary complexes, self disorders, power complexes, and substance abuses (p. 21).

A study conducted by Jacobsen (1988) is an indicator of the long-term risks of obstetrical procedures at birth. Two hypotheses were tested, with significant results: (a) an obstetric care hypothesis, proposing that obstetric interventions may cause injuries leading to adult self-destructive behavior, and (b) an imprinting hypothesis, suggesting that a tendency exists for adults to repeat a traumatic event that occurred during birth. (Imprinting is a term first used by Konrad Lorenz [1935] to refer to a process of learning that occurs immediately after birth in birds. If the birds' mothers are not available they will bond with any moving object and retain the bonding imprint their entire life. Jacobsen and others suggest that a similar process occurs in humans at birth in that they retain imprints of their experiences (Jacobsen, 1988; Cheek, 1975, 1986).

Among births from six major hospitals in Stockholm, for the years 1944-1960, the births of people who later became: drug addicts, or alcoholics; those who later suffered suicides by mechanical means, including hanging and strangulation; and those who later suffered suicides from poisoning by solid or liquid substance; were isolated. This distribution was compared to rates of laboring mothers who received opiates or barbiturates up to 10 hours prior to delivery.

A significant correlation was found between the variables of mothers receiving barbiturates during labor and the births of eventual drug addicts. The conclusion drawn by Jacobsen was that a probable causal relationship exists between obstetric procedures at birth involving barbiturates and later drug use by the grown offspring.

The second hypothesis, that imprinting at birth causes later self-destructive behavior, was tested

three ways. Tests were made to determine (a) whether rates of babies who had been asphyxiated at birth for more than one hour correlated with rates of later suicides by asphyxiation (hanging, strangulation, drowning, and poisoning by gas); (b) whether rates of babies with mechanical birth injuries (breech presentation, forceps delivery, and nuchal entanglements with multiple loops) correlated with rates of later suicides by mechanical means (hanging, strangulation, jumping from heights, firearms et cetera); and (c) whether rates of babies born to mothers who received pain killers during labor were more likely to choose the lifestyle of a drug addict and/or an alcoholic.

Significant results, more than four times that of the controls, were obtained between the variables of asphyxiation at birth and suicides by asphyxiation. That is, suicide victims that chose death by asphyxiation correlated significantly with neonates that suffered asphyxiation for more than one hour at birth. This suggests that the imprinting hypothesis holds true; a tendency may exist to recapitulate a traumatic event occurring at birth at a later time in life.

Similar significance was determined between mechanical birth trauma and suicide by mechanical means. This finding provides further evidence for the imprinting hypothesis by suggesting that the imprinting of mechanical birth injury may be compulsively repeated as a suicide in later life.

Finally, twice the number of mothers of drug addicts had received opiates and three times as many had received barbiturates as had the control mothers. This points to the influence of drugs used during labor upon the later tendencies of the grown offspring toward drug abuse. Significant numbers of alcoholics were not seen among the adult children of mothers who had received pain killers during labor. However, when the group of alcoholics was compared to mothers receiving chloroform anesthesia during labor, significant numbers were found (Jacobsen, 1988).

Leboyer (1976), an obstetrician and pioneer of the natural childbirth movement of the 1960s and 1970s, documented the need to attend to fetal and newborn needs in a much more sensitive way than is commonly practiced. He wrote that practices such as silver

nitrate for newborn eyes, bright lights and low temperatures in the delivery room, forceps deliveries, anesthesia, inversion of the newborn at birth, and other obstetric practices are violent and can cause irreparable harm to the infant. Leboyer suggested dropping the use of technological intervention whenever possible and focusing on the comfort of the newborn in areas of breathing, vision, temperature, bonding, and the interactive recognition of the infant's birthing travail. Leboyer (1976) wrote:

> This is birth. The torture of an innocent. What futility to believe that so great a cataclysm will not leave its mark. It's traces are everywhere - in the skin, in the bones, in the stomach, in the back. In all our human folly. In our madness, our tortures, our prisons. In legends, epics, myths. In the Scriptures. (p. 31)

While Leboyer's (1976) observations and suggestions seem infinitely compassionate and reasonable, some testing has been done to show that his gentle delivery techniques (GDT) may not be as critical to temperament in babies as once thought. Maziade, Boudreault, Cote, and Thivierge (1986) tested the following research questions: (a) Are temperamentally "easy" infants overrepresented in the GDT group in the first year of life? and (b) Are perinatal procedures, such as rooming-in, type of anesthesia, or cesarean birth associated with temperament in infancy?

Samples were drawn from a population of 358 infants (51% female) gathered for other research. At least 5 of the following 7 criteria, selected according to Leboyer's (1976) guidelines, had to be used at a birth for it to be considered part of the GDT group:

- minimum sound
- dimmed lighting in the delivery room
- delay in clamping the cord
- baby skin-to-skin contact with the mother's abdomen
- warm-water bathing of the infant in the delivery room
- no use of forceps
- no or local anesthesia

Fifty-three babies (15%) met this qualification. Other categories tested included 37 cesareans (10%), 50 rooming-in babies (14%), 19 general anesthetics (5%), 255 local anesthetics (71%), 84 with no

anesthetic (24%). Temperament of the babies was rated by the parents using the Carey Infant Temperament Questionnaire (ITQ) at 4 and 8 months of age. The questionnaire consisted of 9 temperament categories from “easy” to “difficult.”

The mean score of the GDT group (n = 53) was compared with the mean score of the non-GDT group (n = 225) by a 2 tailed t-test. No statistically significant difference was found (P = 0.62, P = 0.66). Comparing infants with 2 to 4 days of rooming-in (n = 50) with those with no rooming-in, using the same method, t test analysis of easy to difficult factor scores showed no significant difference at 4 months (P = 0.67) or at 8 months (P = 0.76). An examination of the association between general anesthetics (n = 19) and temperament revealed no significant or substantial difference. Further, when boys and girls were analyzed separately no significant differences in temperament were noted.

The researchers concluded that the techniques inspired by Leboyer held very little or no influence over the temperaments of the tested infants for the 1st year of life. The GDT method of delivery does not appear to lead to “easier” temperament nor more favorable characteristics for that time. Maziade et al. (1986) added that Leboyer would likely assert that obstetricians and nurses do not apply his approach and philosophy fully. The Maziade et al. conclusion was that mothers need not choose a more painful natural delivery method solely on the supposition that it will favor more positive infant development. They do, however, note the need for more research on this issue (p. 294).

My thought here is that while the Maziade et al. (1986) study indicates no distinction between the GDT group and the control, other factors besides temperament may come into play in determining the affects of gentle delivery techniques. For example, the health, size, appetite, digestion, responsiveness, heredity, genetics and other developmental markers of the infants were not factored into the analysis. Also, the impact of some interventions may not be revealed in temperament but rather in relationship, such as impaired bonding as a result of anesthesia (Emerson, 1998; Ruch, 1988). It is logical to conclude that mothers and newborns cannot fully bond when one or the

other is drugged. Further, in my opinion, whether the effects of Leboyer's intentions of being gentle, empathic, aware, considerate, and humane with newborns can be quantified is essentially moot. Treating newborns as we would wish to be treated should be the standard. Often it is not common practice because babies are given the special status of being impervious to pain (Anand & Hickey, 1987; Chamberlain, 1991; Janov, 1983; Pearce, 1992).

This following study suggests that alternative measures should be sought for some of the more invasive and painful interventions such as fetal heart monitoring. In a randomized study of a group of 483 high-risk, obstetric patients in labor, part of the group was treated with fetal heart monitoring, an invasive technique calling for the insertion of the monitor into the scalp of the neonate. Another part of the group was treated instead with auscultation or the technique of listening to abdominal sounds for fetal heart tones. The infant outcome was measured by rates of neonatal death, Apgar scores, cord blood gases, and neonatal nursery morbidity. Results showed no differences in infant outcome between the two groups, except for cesarean sections. The cesarean section rate was markedly higher in scores measuring negative outcomes in the monitored group (16.5), vs. (6.8) per cent in the auscultated group. Presumptive benefits of fetal heart monitoring were not found in the study (Haverkamp, Thompson, McFee, & Getrulo, 1976).

Uterine ultrasound in early pregnancy has become routine in modern prenatal care. It is considered to be a readily available, noninvasive, and safe means of evaluating fetal health, determining gestational age, and assessing the intrauterine environment. Some states have laws requiring at least one ultrasound be performed per pregnancy. Further, it has become a popular means of determining the sex of the unborn child. However, the uncomfortable truth about the long-term effects of ultrasound is that no one knows if it is safe or not (Mitford, 1992). As painless and seemingly harmless as ultrasound is, the following study suggests otherwise.

Significantly lower birth weight was found in a group of newborns born to mothers exposed to frequent ultrasound monitoring (intensive group) when compared to a group of babies whose mothers had received only

one ultrasound treatment (control group). The intensive group, selected at random, was made up of 1415 pregnant women at 16-20 weeks gestation. Through the course of their pregnancies they were given five ultrasound and continuous Doppler flow examinations (an ultrasound technique used to measure placental blood flow which can assist in determining intrauterine pathology). The control group, consisting of 1419 randomly selected pregnant women received a single ultrasound treatment. Newborns in the intensive group showed significantly higher intrauterine growth restriction when expressed as birth weight than the control group. The researchers suggest that repeated prenatal ultrasound imaging and Doppler flow studies should be restricted to those women for whom the information is likely to be of clinical benefit, rather than be used routinely (Newnham, Evans, Michael, Stanley, & Landau, 1993).

While technological breakthroughs in obstetrics may be considered essential, long-range effects must be carefully examined, not only with mothers, but with newborns, as well. Salk, Lipsitt, Sturner, Reilly, and Levat (1985) conducted a blind study into the possible relationship between falling perinatal mortality, and rising adolescent suicide rates. The results may duplicate the imprinting discovery of Lorenz (1935) suggesting that the vulnerable neonate may retain bodily memories of birth. This study again points to the possibility of tragic long-term outcomes of perinatal intervention.

Forty-six risk factors were used to determine possible reasons for suicides by 52 teens, as compared to 2 controls. Of the 46 factors, 3 were found to be significant, (a) respiratory distress for more than 1 hour at birth, (b) no prenatal care before 20 weeks of pregnancy, and (c) chronic disease of the mother during pregnancy. The variable of respiratory distress at birth correlated significantly with later suicide rates. This outcome suggests that the imprinting of asphyxiation at birth may be recapitulated later in life, creating an urge to complete the process of death.

Another study pointing to a connection between obstetric intervention and subsequent suicide rates indicates an urgent need for more in-depth, longitudinal studies. Jacobsen (1988) demonstrated

significance between age cohorts in various regions of the USA, born between 1912 and 1920, and their subsequent suicide rates 20 and 40 years later. Of the 12 risk factors considered in the multivariate analysis, 3 were significant: (a) parental alcoholism, (b) a broken home during childhood, and (c) birth injury. When the study was repeated, using different geographical areas and age cohorts, and separating the population into white males and white females, black males and black females, the results indicated a higher significance correlation for birth injury with suicide than for any other category. That is, there was highest correlation between those suffering injury at birth and suicide. This suggests the dependency of the suicide rate, at least in part, on birth periods, the geographical area of birth, and birth injury. As such, obstetrical procedures causing birth injury, such as forceps or vacuum assist may play a part in later adult self-destructive behavior .

The following responses in fetuses to routine amniocentesis: increases in heart rate, remaining motionless for 2 minutes, and breathing significantly slower for 4 days have been recorded (Hill, Platt & Manning, 1979; Manning, Platt & Lemay, 1977; Neldam & Pedersen, 1980; Ron & Polishuk, 1976). Reasons for these reactions have not been determined but the implications are that amniocentesis is not a harmless intervention.

Circumcision is a neonatal procedure designed to remove the foreskin of the penis in healthy newborn males. Some ostensible reasons for circumcision are: tradition; religious custom; to prevent infection; so that the child doesn't feel self-conscious when he notices he is different from his father or other boys; because, in the opinion of some, it looks better; and for financial remuneration (Bigelow, 1995). About one in six males in the world have been circumcised, mostly for religious reasons (To, Agha, Dick, & Feldman, 1998).

Circumcision is a procedure that sometimes yields dire consequences. Newborns can be maimed when doctors accidentally cut too deep or use a laser a size too large. On a larger scale, "normal" circumcision can cause a loss of sensation in the penis since the glans which is meant to protect it has been removed. Without the protection of the glans, the head of the penis

becomes toughened causing a loss of sensation, and often affecting sexual responsiveness. (Bigelow, 1995)

Immerman and Mackey (1997) write that the process of circumcision catalyzes a, "reorganization/atrophy of the brain circuitry" causing lower sexual excitability, and minimizing "...any pheromonic qualities" (p. 265). They go on to point out the "benefits" of lowered arousal, in pubescent boys.

> Inferential data support the hypothesis that a practical consequence of circumcision, complementary to any religious-symbolic function, is to make a circumcised male less sexually excitable and distractible, and hence, more amenable to his group's authority figures. (Immerman & Mackey, 1997, p. 265)

Baby boys who have been circumcised have short-term alterations in sleep patterns, frequency of feeding, fussiness, crying, behavior, and heart rate (Brackbill, 1979). In a recent study comparing the measured rates of pain of a group of circumcised babies after receiving vaccinations, with a group of uncircumcised babies vaccinated in the same way Taddio, Goldback, and Stephens (1995) found the pain scores to be higher in the circumcised group. Scores for behavioral pain and length of crying were higher among circumcised boys as well.

A well-documented benefit of circumcision is the occurrence of less urological infection in men and boys (Bennett, Gill, & Kogan, 1998; To, et al., 1998). The ostensible reason given for this is increased cleanliness. According to the records of To et al. however, in spite of the significantly higher risk of infection in uncircumcised males, "195 circumcisions would be needed to prevent one hospital admission for urinary tract infection (UTI) in the 1st year of life" (p. 1813). In other words, circumcision may lower the significance of UTI in boys, but to an insignificant degree.

Circumcision, as routine as it is, has many risks and long-term consequences. Further, it is painful. A reasonable approach to operating on a newborn in this way is to create the means to educate new parents as to the possible benefits and drawbacks of the procedure. Unfortunately, this is not current practice in prenatal programs. Justifications such as being able to exercise more control over pubescent boys and

the occurrence of less urinary tract infections in males are not standing up to the light of research and common respect. Often, routine obstetric interventions are miracles that save lives. Often they are unnecessary and dangerous. Studies such as this one can help to uncover the real impact of these measures, when they are necessary, and when they are not. More research is urgently needed.

Conclusion

The remembrance of the pre- and perinatal realms is an uncommon phenomenon. While its existence spans the history of humanity, its written history is barely a century old. Many cannot conceive of remembering their birth. For those who can, however, I have cut a rather broad slice of the literature to allow the concept to take root and, for some, to actualize. Unfortunately, mainstream psychology sources are virtually devoid of material on this subject. Instead I have included various opinions on the concept of repression, since without it pre- and perinatal memory recovery would not exist.

The beginnings of perinatal psychology were recorded by psychoanalysts. A brief section describes the opinions of Freud, Rank, Fodor, and Winnicott. This is followed by a discussion of many concepts of memory and consciousness as viewed through a holonomic lens. Wade's (1996) concept of "fetal" and "transcendent" consciousness, for example, while helpful in understanding perinatal recall would make no sense within the Newtonian-Cartesian paradigm.

Phenomenological studies of very early recall often demonstrate a surprising degree fetal and newborn intelligence. To illustrate these findings I have included several studies of pre- and perinatal awareness and learning potential, like Claira (Sallenbach, 1993, 1994) the fetus that communicated with her expectant family, and the newborns who remembered "The Cat in the Hat Comes Back" (De Casper & Spence, 1982).

Psychotherapies of ordinary and non-ordinary consciousness were reviewed, including, hypnosis, breathwork, LSD, primal, and bodynamic. These are the therapies used by most people attempting to access pre- and perinatal memory. Though psychotherapy with infants and children is not directly relevant to the current study, I included a short section about it

because it demonstrates the depth and breadth of this field.

The review concludes with a section about routine obstetric technology. I felt this was an essential inclusion, since results of phenomenological inquiry into the remembrance of the experience of the pre- and perinatal so often demonstrate findings that suggest the serious impact of these interventions.

CHAPTER 3

Research Methodology

In this culture, we have overlearned a particular form of intentionality. This is an effortful, striving form, the nature of which is captured well in the phrase "will power." In other situations, however, another form of intentionality is more appropriate. This is a form of passive volition or effortless, strivingless intention that is more like a gentle wish...

William Braud (1992, p. 3)

This study asks the question, What is the experience of healing through the remembrance of the pre- and perinatal? It utilizes phenomenological methodology since this approach facilitates a focus upon experience itself as opposed to its quantification or control. This chapter includes an overview of existential phenomenology, a description of the six steps used to collect and analyze the data, and sections on validity, and the limitations and delimitations of the research.

Overview

In the term, "existential phenomenological psychology," existential refers to the philosophy of existence, the study of being. In large measure it

focuses on subjective experience. Phenomenological describes the methodology used to study existential phenomena. In existential phenomenological research, a phenomenon or a type of experience is selected for study. This selection could be anything as basic as the experience of gardening, driving a delivery truck, or feeling afraid. It also could be as unusual as trapeze artistry, being an astronaut, or remembering birth.

The methodology consists of a careful analysis of reflective interview data such that it reveals the common and unique underpinnings of an isolated experience. By applying visual, aural, and intuitive faculties, individually, to the language, inflections, movement, and intentions of a small number of co-researchers the researcher can identify and group like areas of feeling, emotion, and perception. Then by combining those results under broader but "true to the phenomena" categories, the essence or structure of the phenomenon emerges (Hycner, 1982, p. 1). This "explication" of interview data, a careful observance of phenomenological steps applied to human expression in an artful manner, is a balance that comes with practice and patience.

The philosophies of existentialism and phenomenology took root in continental Europe in the first half of the twentieth century. Late in the 1940's the impact of these emerging bodies of thought was felt in North America. Concern for the individual had long been overshadowed by religious fanaticism, and the technological onslaught brought about by the industrial revolution. With the central focus of existential thought being existence as it is experienced by the individual, the North American populace was ripe for its arrival. The influence of existentialism exists in virtually every form of human thought and expression, including the novel, theater, poetry, art, and theology (Stumpf, 1975). An example of this influence is existential psychotherapy which objects to therapies that focus on mechanistic or unconscious processes rather than the unique characteristics and experiences of the individual. In the arts, theology, psychology, and in general, whenever there is an attempt to illuminate human existence and will, a reflection of existentialism is present.

Soren Kierkegaard (1813-1855), a Danish religious thinker, based much of his work on the fundamental themes and struggles of human beings. He is considered to have sown the seeds of existential thought. Martin Heidegger (1889-1976) and Karl Jaspers (1883-1969) developed this philosophy and are the credited founders of existentialism. Most notably, they questioned the scientific paradigm that human beings exist separately from the world, and instead viewed them as integral and inseparable with the world and its objects, in constant interrelationship. This objection to the notion of separation in the scientific paradigm of the time is an early indication of the emergence of a more holonomic way of thought (see the literature review). Further, the term "co-researcher" is used in phenomenological research as an extension of this conviction. Instead of "subject" and "researcher" denoting the "observed" and the "observer," a co-researcher is part of the shared experience with the researcher; one truly cannot be separate from the other.

Edmund Husserl (1859-1938) was the founder of phenomenology. His focus was on the development of research that was unbiased, and which revealed phenomena as they appear, are lived, and experienced (Misiak & Sexton, 1973). Accordingly, he coined the term "life-world" or "lebenswelt," the foundation upon which existential-phenomenological thought is built. Von Eckartsberg (1986) defined lebenswelt this way, the place of interaction between persons and their perceptual environments and the world of experienced horizons within which we meaningfully dwell together. It is the world as we find it, prior to any explicit theoretical conceptions. (p. 2)

"The life-world is...co-constituted or co-created in the dialogue of person and world" (Valle & King, 1978, p. 4). As such, we "co-constitute" one another, human beings and the world in constant dialogue, one having no meaning without the other.

Through the eyes of the phenomenological psychologist, consciousness is always "of something," that is, it always has an object. Zaner used the term "consciousing" to demonstrate the active nature of consciousness (1970, p. 17). "Intentionality" has a complex meaning and refers to the ongoing nature of

consciousness. To intend something is to become conscious of it, or to be aware of its presence. An object is intended if one is conscious of it. Consciousness, however, does not exist without objects to intend, and conversely, objects do not exist if they are not intended.

Valle and Mohs (1998) believe phenomenologists to be lacking in their description of consciousness when not including the concept of "pure consciousness." Here they refer to the "stuff" of which intentional consciousness is made, of which we are all made. This is the formless, nameless, spiritual aspect of existence, without intention.

Phenomenological psychology can be seen as a complement to behavioristic psychology in its focus on the inner world of experience. The latter utilizes natural scientific methodology to measure, explain, and change behavior. This mainstream methodology makes three basic assumptions: (a) that phenomena be observable, that is, perceived through at least one of our five senses, (b) that phenomena be measurable, and (c) that two or more persons can agree upon the existence and qualities of any given phenomenon.

By contrast, the existential-phenomenological psychologist seeks to understand human experience, including its non-measurable, uncontrollable qualities, like joy or hate. This researcher asks the "what" of experience, not the "why." In this sense, through a descriptive and disciplined investigation of experience itself, phenomenology picks up where behaviorism leaves off. The assumption underlying this type of research is that human beings of a shared culture, that is, shared language and heritage, will identify experience in like manner (von Eckartsberg, 1986). Therefore, by gathering descriptions of the remembrance of birth, and the times before it and after it, from a small sample of people of Western culture, and then applying "hermeneutic" or interpretive technique, I have extracted a composite description of the "prereflective structure" of the experience. Husserl conceived of phenomenological research in terms of the examination of the lebenswelt or "back to the things themselves." He believed that to the extent possible the study should be of pure phenomena, prior to any reflective thought process, interpretation, or intellectualization. I have worked

toward this end.

Preliminary steps in applying hermeneutic techniques include the identification of personal assumptions, preconceptions, and biases of the researcher, in a process called "bracketing" or "phenomenological reduction" (Giorgi, 1985). The reduction requires the researcher to hold the identified attitudes and biases in conscious awareness throughout the process, keeping the unconscious or contaminating effects of them to a minimum. My personal biases and assumptions are listed later in this chapter.

Written or verbal reports of the phenomenon being studied are called "life-texts" or "protocols." These data are transcribed verbatim, then explicated, as the researcher identifies common and significant themes, and translates them into a universally understood language, using psychological and phenomenological terminology (Giorgi, 1975; von Eckartsberg, 1986). With this process of explication, what has been implicit becomes explicit, revealing the underlying essence or structure that is the common thread of the phenomenon.

Research Procedure

This study is an investigation of the experience of the remembrance of the pre- and perinatal by posing the following question to a small number of co-researchers, What is the experience of healing through the remembrance of the pre- and perinatal? The six basic steps are:

1. Selection of co-researchers:

Participants were found through advertisements on school bulletin boards, the internet, relevant journals, such as Primal Renaissance and Connections, and by word of mouth. The four requirements for participation included (a) having had the experience of remembering some aspect of the pre- and perinatal realm, (b) the ability to articulate the experience, (c) that the experience yielded a pivotal healing change in their life, either physically or psychospiritually, and (d) the willingness to participate.

2. Phenomenological reduction, or "bracketing":

the act of holding personal prejudice or preconceptions in consciousness on the part of the researcher throughout the interview and data analysis processes.

3. An oral interview:

An interview was conducted face-to-face or by telephone and recorded on audio tape. The question asked was, What is the experience of healing through the remembrance of the pre- and perinatal?

4. A follow-up interview:

A second interview was conducted by reading the transcribed first interview aloud to the co-researcher. This process allowed the participant to add, take away from, or modify the first interview. A follow-up question was asked at this time, What was healing about this experience for you? (See Appendix K.)

5. Data analysis:

Hycner's (1982) “Guidelines for the Analysis of Interview Data” (15 steps) was utilized. (See Appendix C.)

6. A Demographics Form:

A demographics form focusing on aspects of abusive domestic situations was completed to examine claims of child abuse made by the co-researchers. (See Appendix F.)

These steps are now described in more detail.

Selection of Co-researchers

This researcher has been meeting and talking with people about the experience in question for nearly 5 years. Through referrals by friends or associates, in chance meetings at book stores, seminars, or workshops

based in birth-centered psychotherapy, and through internet, bulletin board, and journal communications, people who hold an interest in the remembrance of the pre- and perinatal have become known to me. I have requested through these avenues that those who have been able to produce significant changes in a condition, either psychospiritual or physical, through the remembrance of the pre- and perinatal, and who might like to participate in this study, be referred to me.

Polkinghorne (1989) asserts that a relatively small number of co-researchers can explicate the essence of the phenomenon. Accordingly, where sufficient depth of description is present, a small sample can reveal the structure of any human phenomenon (Giorgi, 1985; Kruger, 1979; Lingis, 1986). As such, I have selected a small number of participants. I have aimed at variation in the method of access to the experience by including participants utilizing differing therapeutic modalities, such as primal therapy, birth regression, holotropic breathwork, and hypnosis, while planning upon explicating the underlying, common essence of the remembrance of the pre- and perinatal (Polkinghorn, 1989).

All of the co-researchers were Caucasian, had college experience at the bachelor's level or higher, and were born and raised in the USA. Of the 7 participants, 4 were female, 3 were male, and the average age was 44 years. While all of these individuals related experiences with the remembrance of the pre- and perinatal realm that resulted in deeply meaningful changes, they claimed to have had little or no knowledge of pre- and perinatal psychology before experiencing birth regressions. Among the changes they attested to was the mitigation or the complete resolution of conditions of asthma, migraine headaches, visual impairment, arthritis, obsessive-compulsive tendency, phobia, depression, suicidality, and syncope. Since they all believe they gained substantially from their pre- and perinatal remembrance, they do not differ from this researcher in their opinion of the phenomena.

Phenomenological Reduction or "Bracketing"

The term "individual phenomenological reflection," or (IPR), was coined by Colaizzi (1973) to describe his recommended self-reflective process, wherein the

researcher brings to conscious recollection experiences with the phenomenon being studied. In this way and by bracketing attitudes, assumptions, and biases that come to mind, the researcher can avoid contaminating the data with unconscious material. Bracketing is done during the entire process, from interviewing, through data analysis. The following is a list of my own beliefs and biases about the remembrance or reexperience of the perinatal. I have tried to be as honest as possible in this assessment and have included attitudes that do not necessarily reflect my rational belief system.

- The experience is healing.
- It requires courage.
- Most people know little or nothing about it.
- Memory is in the body, cellularly.
- The transcendent self records all experience.
- Mainstream psychology looks askance at this type of research.
- The experience is sacred.
- It is frightening, sometimes terrifying.
- It results in a deeper, more discrete sense of "self" and paradoxically, an increased feeling of oneness with all creation.
- It is an intensely private experience.

The Interviews

A pseudonym was selected by 4 of the participants and used throughout the research procedures. The remaining 3 co-researchers chose to use their own first names. An audiotaped face-to-face or telephone interview was held with each of the co-researchers asking the question, "What was the experience of healing through the remembrance of the pre- and perinatal?" The taped interviews were transcribed verbatim by the researcher and listened to a second time, checking for accuracy. A second interview was held one or two weeks later, by reading the transcribed material back slowly, and allowing the co-researcher to respond aloud to the material, adding, deleting or modifying its contents. The combination of these interviews can be found in Appendix I. The researcher endeavored not to bias the interview by leading the co-researchers with questions

of personal interest and to keep bracketed material in awareness while focusing and magnifying the feelings and expression of the co-researcher.

The Follow-up Question

A second question was posed to the co-researchers at the end of the second interview in order to provide a clear description in their own words of the healing effects they derived from the experience of the remembrance of the pre- and perinatal. That question was, What about this experience was healing for you. The answers to this question can be found in Appendix K, and are summarized in Chapter 4.

Data Analysis

Recorded protocols were transcribed verbatim by this researcher. These data were analyzed according to a procedure created by Richard H. Hycner (1982, Appendix C). Hycner (1982)writes,

> This article is an attempt to spell out in a step by step manner, a series of procedures which can be utilized in phenomenologically "analyzing" interview data. Giorgi, Fischer, and von Eckartsberg (1971) strongly emphasize that any research method must arise out of being responsive to the phenomenon. No method (including this one) can be arbitrarily imposed on a phenomenon since that would do a great injustice to its integrity. On the other hand, there are many researchers who simply have not had enough philosophical background to begin to even know what "being true to the phenomenon" means in relation to concrete research methods. The following guidelines have arisen out of a number of years of teaching phenomenological research classes to graduate psychology students and trying to be true to the phenomenon of interview data while also providing concrete guidelines. (p. 1)

Step 6 of these guidelines required the researcher to train an independent researcher familiar with the phenomenological method. Camille Nichols, JD, MFCCI, agreed to serve as my independent researcher. Camille recently completed a master's degree in marital and family therapy at The College of Notre Dame. Her thesis was a phenomenological study, entitled, "Meeting the Unborn: A Phenomenological Inquiry into Prenatal and Birth Experience."

The independent researcher studied the research

proposal and Hycner's unpublished booklet, "Some Guidelines for the Phenomenological Analysis of Interview Data." When she felt prepared, we met and reviewed the methodology and assuring that our understanding of the data analysis was mutual. I then provided her with a transcribed interview to be analyzed to the point of identifying the general and relevant units of meaning. Camille read the protocol and determined the units of general meaning, or those statements that expressed unique, coherent meaning. >From the units of general meaning, those that illuminated the current study were extracted and logged as units of relevant meaning.

Comparing the results of the independent researcher's analysis of the interview with my own analysis revealed essentially the same units of general and relevant meaning. This provided solid validation with which to go forward with the rest of the analysis, from Step 7, eliminating redundancies.

Demographics Form

Upon the discovery of an inordinate amount of child abuse claims made by the co-researchers when the data were analyzed, the researcher designed a demographics form to determine the types and extent of abuse that occurred in their childhood homes. These forms were completed by the participants and can be seen in Appendix F. A summary of this information can be found in Chapter 4.

In summary, seven audiotaped interviews were conducted and transcribed verbatim by this researcher, asking the question, What is the experience of healing through the remembrance of the pre- and perinatal? A second interview was conducted by reading back the transcribed material to the co-researchers, and recording any responses. The results of this interview blended with the first interview are in Appendix I, Protocols. A follow-up question was asked, recorded, and transcribed by this researcher, What about this experience was healing for you? (Appendix K).

The independent researcher verified the units of relevant meaning for one interview. When it was ascertained that this researcher's relevant meaning units were virtually identical to those identified by the independent researcher (see Chapter 4, Tables 1a and 1b), the researcher then moved on through the rest of Hycner's guidelines. The following is a summary of

those guidelines. The complete guidelines are in Appendix C.)

Summary of Hycner's Guidelines for Data Analysis (Complete guidelines in Appendix C.)

1. Transcription. (a. Returning to the participant for a follow-up interview. b. Asking a follow-up question.*)

2. Bracketing.

3. Listening to the interviews for a sense of the whole.

4. Delineating units of general meaning.

5. Delineating units of relevant meaning.

6. Consulting with an independent researcher for validation.

7. Eliminating redundancies.

8. Clustering units of relevant meaning.

9. Determining themes from the meaning clusters.

10. Writing a summary for each individual interview.

11. Returning to the participant with the summary and themes; conducting a second (third*) interview if requested by the co-researcher.

12. Modifying themes and summary.

13. Collecting the completed demographics form and summarizing.*

14. Identifying general and unique themes for all interviews.

15. Contextualizing of themes.

16. Composite summary.

*Parenthetical additions reflect this researcher's modifications to Hycner's guidelines.

A procedure, known as a "zigzag" process, of going back and forth from the transcript to the units of relevant meaning to the clusters of meaning to the themes was used in order to verify that each successive unit of meaning, cluster, and theme remained true to its intended meaning. The zigzag process is demonstrated in detail in Chapter 4, Tables 4a and 4b.

Chapter 4 contains the results and discussion of the study, the outcome of following Hycner's guidelines for the analysis of interview data. Cluster headings and individual themes which determine the underlying structure of the experience are sorted and listed in tables. General themes were developed through further reduction. The individual, general and unique themes are listed in Table 6. Summaries of each interview incorporating the themes were composed and returned to the participants for approval, modification, or another interview (Appendix J). The themes are then presented contextually, that is, giving proper perspective to their place in the original text. A composite summary of all of the interviews follows. This summary describes the traumatic "world" of the pre- and perinatal realm as described by the co-researchers of this study.

Limitations and Delimitations

The natural scientific researcher endeavors to root out as many confounding variables as possible. In this way, the study will be as free from bias as possible. Likewise, the phenomenologist follows the rules of the phenomenological interview style in not imposing an outside viewpoint with spontaneous questioning. The study is kept free from contamination by using the words and ideas of the co-researcher to stimulate expression.

I believe that this single restriction can make the difference between a true expression of the structure of an experience and one that falls short of this goal. On the other hand, the co-researchers may not address the issues as directly as the researcher hopes since it is the experience of the co-researcher that

is being elucidated. For example, one of this researcher's biases is the belief that the experience of remembering the perinatal can be profoundly healing. Accordingly, I have chosen co-researchers who attest to having had profound healing effects from the experience, that is, people who agree with me. Still, this researcher could not predict that they would address this issue directly, nor would I impose my will to know by asking them. Their personal testimony will bring this information forward, or not. Further, I am not asserting that a birth remembrance is or will be healing for everyone who attempts it, for this study focuses only on people who report that their experience was healing and contains no co-researchers with differing opinions.

Validity

Fundamentally, the subjective nature of the phenomena being studied in phenomenological inquiry precludes the degree of objectivity demanded by the natural scientific community. Feelings, emotions, and perceptions cannot be measured, only described.

A criticism made by the scientific community is that phenomenological research does not have objective measures of validity. According to Hycner (1982) the irony of this complaint is that ordinary research instruments are tested for validity by other instruments which themselves might have questionable validity. In the end, it is a number of researchers that attest to the credibility of an instrument rather than the test instrument. The validity of phenomenological research is actually ascertained in the same way. While test instruments are not used, a consensus of opinion of other researchers at a number of levels is the assessment of validity. Hycner (1982) suggests five ways that phenomenological research is validated, in order of increasing sophistication:

1. The co-researcher, in recognizing the reduction as valid for them or not.

2. The researcher, in sensing the resonance of the distillation, that is, do the themes, summaries and the composite summary feel "true to the phenomena"?

3. The research committee, in evaluating the results among themselves.

4. Checking the results against current literature.

5. Submission of the results to the scientific and lay communities for discussion and comparison from a large number of perspectives. (pp. 25-6)

Another issue concerning validity is replicability. That an experiment be reproducible is a main tenet of the natural scientific community. Giorgi (1975) points out that while phenomenological research can be replicated in the main, there is bound to be divergence in results because the same phenomenon is being viewed slightly differently by varying researchers. Giorgi (1975) writes,

...the chief point to be remembered with this type of research...[is] whether a reader, adopting the same viewpoint as articulated by the researcher, can also see what the researcher saw, whether or not he agrees with it. This is the key criterion for qualitative research. (p. 96)

CHAPTER 4

Results and Discussion

Another part of it is that I gained a spiritual awareness of my purpose through this work, and of my light, my holiness, that has been a tremendous help to me.

Marisa

Well, the healing itself, okay, I had this vision change. My eyes got a lot better But it was more than that. It made me realize that there's something magical about life and the physical body. I wouldn't have acknowledged that unless I had experienced it personally.

Karlton

Introduction

This chapter presents the data analysis as it is used in the current study. The reader is guided through the process in stepwise fashion. Results obtained through the analysis are expressed as themes: individual, general, and unique, and in various other forms. Specific representations of the themes, for example, are depicted as excerpts from the protocols. The Composite Summary, which postulates what the "representative composite subject" might experience in healing through the remembrance of the pre- and perinatal, is another part of the presentation. Depictions of the work of Stanislav Grof and Arthur Janov are given through excerpts of the protocols, along with a comparison of the results with the reviewed literature. The chapter concludes with a discussion of the results of the investigation, its implications and limitations, and some suggestions for further research.

Data Collection From Written and Oral Protocols

Upon receipt of the signed consent form (Appendix A), a questionnaire modeled after that of van Kaam (1966) (Appendix B), was sent to the participants. A written response was requested to the question, What is the experience of healing through the remembrance of the pre- and perinatal? Due to the reluctance of the co-researchers to submit written material, however (three written protocols were received), this researcher destroyed the written protocols and conducted oral interviews, and oral follow-up interviews for all the participants instead.

Excluded Data

One of the protocols (Jesse's) was found to be largely about other people's perceptions and veered

away from his personal experience with the pre-and perinatal. Therefore, I bracketed the portions of Jesse's life-text that were pertinent to his personal experience, including only those bracketed portions in the data analysis. Later, after the analysis was complete, and while comparing the results of the current study with the reviewed literature, I realized that Jesse's ancestral memories were probably what Grof (1985) describes as a transpersonal experience, and should have been included in the data analysis. The omitted transcript is illustrated and discussed under the heading, Jesse's Transpersonal Experience.

Bracketing

The following is a list of my own beliefs and biases about the remembrance of the pre-and perinatal. I have tried to be as honest as possible in this assessment and have included attitudes that do not necessarily reflect my rational belief system. Bearing these beliefs and biases in mind during the interviewing and data analysis phases of the phenomenological process is called, "bracketing," and is considered essential to fair and unbiased research.

- The experience is healing
- It requires courage.
- Most people know little or nothing about it.
- Memory is contained in the body, cellularly.
- The transcendent self records all experience.
- Mainstream psychology looks askance at this type of research.
- The experience is sacred.
- It is frightening, sometimes terrifying.
- It results in a deeper, more discrete sense of self and, paradoxically, an increased feeling of oneness with all creation.
- It is an intensely private experience.

A Sense of the Whole

After interviewing the participants and listening to their recordings, this researcher came to a sense of the "whole experience" for each co-researcher. The following reflects my impression:

- Marisa: A long, painfully lonely experience by a strong, determined being.

- Douglas: Desperation and courage mark this journey, punctuated by close brushes with death.

- Karlton: The quintessential birth experience insofar as his remembrance took him deeply into bodily memory, far from the interference of thought.

- Rachel: A remembrance of the roots of rage being one with the roots of illness.

- Caroline: A sad, extraordinarily abusive experience, with a surprising degree of recovery.

- Amy: A story of courageous determination to be a whole person.

- Jesse: Swept along suddenly into a realm he never imagined existed, Jesse open-heartedly took healing where he found it.

Transcription

The interviews were transcribed verbatim by this researcher. The transcripts were then broken down into units that expressed unique, coherent meaning. Each of these phrases or sentences were delineated and recorded as units of general meaning. Of the units of general meaning those that directly pertained to the investigated phenomenon were underlined, extracted from each protocol, and logged as units of relevant meaning. Redundancies were eliminated.

Independent Researcher

An independent researcher was trained to conduct the above procedures for one interview only, through Step 5, Delineating Units of Relevant Meaning. She read Caroline's protocol to determine the units of general meaning. Of the units of general meaning, she extracted those that were found to illuminate the current study and listed them as units of relevant meaning. The units of relevant meaning rendered by the researcher (Table 1a) and those by the independent researcher (Table 1b) were virtually identical, thus providing sufficient validation for the researcher to continue with the analysis on her own. The numeration, 16-105 with missing numbers between, reflects the original numeration of the units of general meaning

exclusive of non-essential units, so that the reader can follow the sequence of decisions being made.

Table 1a

Units of Relevant Meaning for Caroline's Protocol Determined by the Researcher

16. Using clinical hypnosis they regressed her to her birth.
18. Every time they reclaimed a trauma that happened at her birth, her body would respond by correcting the trauma right there as she lay on the couch.
20. One of the first things they recovered was a heart trauma.
21. This was an emotional response to her birth.
22. Her heart had been in a great deal of pain for a long time.
24. She asked him about it and they went into hypnosis.
25. Her mother had wanted a boy.
26. She was a girl, of course.
27. She was born with the feeling of a broken heart.
29. They went into the feelings about this.
30. She cried.
31. She felt like a great weight was being lifted off of her chest.
32. That was the physical response she had to the fact that her mother had wanted a boy and not a girl.

33. She had at least 12 sessions with Dr. C. where she felt like she was
34. She could not breathe.
35. There was a great deal of panic.
36. There was a great deal of feeling of dying.
37. There was anger.
38. The anger came from the fact that she was doing well until her mother took a drug so she wouldn't feel the labor.
39. The drug slowed her down.
40. She was unable to move.
41. This infuriated her.
42. They went into that memory 10 or 12 times.
43. She felt a great deal of untwisting and freeing up taking place in her body.
44. She'd suffered with the fear of poisoning all her life.
46. She was on a very strict vegetarian diet for 12 years.
47. She was trying to purify her diet so she could be free of poisons in her body.
48. One day Dr. C. and she regressed her to just after her birth when she was receiving a transfusion.
49. She was an unexpected RH baby.
50. The first transfusion was the wrong blood.
53. Her body went into complete shock.
54. For about 30 minutes she convulsed as she had this memory.
55. Almost immediately they got the right blood.
56. They realized something was wrong.
57. Afterwards, her fear of food went away and she went back to eating meat.
58. She eats anything she wants now.
62. It stemmed from the birth.
63. That was resolved in one session.
64. She was really surprised.
65. It's really odd the way they gave her transfusions.
66. They would cut about an inch long.
67. She has scars all over her body.
68. Three on each foot, one on each hand, and several on her head from the transfusions.
69. They cut her without anesthetic.
70. The cut was about an inch long.
71. So if it was on her hand, the cut would cover her whole hand.
72. And then they would put a wooden splint there.
73. They gave her blood through a standard tube.

74. When Dr. C. put her under, she felt the pain of the knife.
75. She could feel the pain as if she were having surgery without anesthetic.
76. She learned to leave her body.
77. It was easy for her to leave her body from that point on.
78. She was being cut quite a bit.
79. They didn't realize she could feel it.
80. They still think babies don't feel it.
81. They certainly do feel it!
82. It was horrible.
83. They cut her feet first.
84. When she started feeling the second cut, she said, "Oh gee I'm feeling real goofy. I don't feel pain anymore."
85. She started doing that from that point on to handle the pain that she was subjected to in her life, at her birth, and from abuse when she was a child.
86. She was sexually and physically abused.
87. Her father sexually abused her.
88. She was able to leave her body at that point.
89. She had done it so often as a baby.
91. She doesn't really feel much.
92. Then there was her life-long need to have a window open.
93. Some of that came from birth from feelings of panic around not feeling able to breathe.
94. As you come out you're being squeezed and feeling like you're being suffocated.
95. She had a pre-birth memory of her parents having sex.
96. She felt the pressure.
97. There was no concern for her welfare.
98. It was probably rough sex.
100. She felt cut off from oxygen.
101. She felt panic.
102. The fear of not being able to breathe and having to have the windows left open after reliving that memory.
103. She used to not be able to allow anyone to spray anything around her, like perfume or hair spray.
104. She would be in a tremendous state of panic.
105. She felt she wouldn't be able to breathe.

Table 1b

Units of Relevant Meaning for Caroline's Protocol
Determined by the Independent Researcher

16. Using Clinical hypnosis they regressed her to her birth.
18. Every time they reclaimed a trauma that happened
at her birth, her body would respond by correcting the trauma
right there as she lay on the couch.
20. One of the first things they recovered was a heart trauma.
21. This was an emotional response to her birth.
22. Her heart had been in a great deal of pain for a
long time.
24. She asked him about it and they went into hypnosis.
25. Her mother had wanted a boy.
26. She was a girl, of course.
27. She was born with the feeling of a broken heart.
29. They went into the feelings about this.
30. She cried.
31. She felt like a great weight was being lifted off
of her chest.
32. That was the physical response she had to the fact
that her mother had wanted a boy instead of a girl.
33. She had at least 12 sessions with Dr. C. where she
felt like she was being squished and squashed
coming out of the birth canal.
34. She could not breathe.
35. There was a great deal of panic.
36. There was a great deal of feeling of dying.
37. There was anger.
38. The anger came from the fact that she was doing
well until her mother took a drug so she
wouldn't feel the labor.
39. The drug slowed her down.
40. She was unable to move.

41. This infuriated her.
42. They went into that memory 10 or 12 times.
43. She felt a great deal of untwisting and freeing up taking place in her body.
44. She'd suffered with the fear of poisoning all her life.
46. She was on a very strict vegetarian diet for 12 years.
47. She was trying to purify her diet so she could be free of poisons in her body.
48. One day Dr. C. and she regressed her to just after her birth when she was receiving a transfusion.
49. She was an unexpected RH baby.
50. The first transfusion was the wrong blood.
53. Her body went into complete shock.
54. For about 30 minutes she convulsed as she had this memory.
55. Almost immediately they got the right blood.
56. They realized something was wrong.
57. Afterwards, her fear of food went away and she went back to eating meat.
58. She eats anything she wants now.
59. She thought she gave up meat because of noble longings.
60. The purer you are the more spiritual you are.
61. It boiled down to wanting to purify her body out of fear of toxic poisoning and dying from the toxins in her food.
62. It stemmed from the birth.
63. That was resolved in one session.
64. She was really surprised.
65. It's really odd the way they gave her transfusions.
66. They would cut about an inch long.
67. She has scars all over her body.
68. Three on each foot, one on each hand, and several on her head from the transfusions.
69. They cut her without anesthetic.
70. The cut was about an inch long.
71. So if it was on her hand, the cut would cover her whole hand.
72. And then they would put a wooden splint there.
73. They gave her blood through a standard tube.
74. When Dr. C. put her under, she felt the pain of the knife.
75. She could feel the pain as if she were having surgery without anesthetic.
76. She learned to leave her body.

77. It was easy for her to leave her body from that point on.
78. She was being cut quite a bit.
79. They didn't realize she could feel it.
80. They still think babies don't feel it.
81. They certainly do feel it!
82. It was horrible.
83. They cut her feet first.
84. When she started feeling the second cut, she said, "Oh gee I'm feeling real goofy I don't feel pain anymore."
85. She started doing that from that point on to handle the pain that she was subjected to in her life, at her birth, and from abuse when she was a child.
86. She was sexually and physically abused.
87. Her father sexually abused her.
88. She was able to leave her body at that point.
89. She had done it so often as a baby.
91. She doesn't really feel much.
92. Then there was her life long need to have a window open.
93. Some of that came from birth from feelings of panic around not feeling able to breathe.
94. As you come out you're being squeezed and feeling like you're being suffocated.
95. She had a pre-birth memory of her parents having sex.
96. She felt the pressure
97. There was no concern for her welfare.
98. It was probably "rough" sex.
100. She felt cut off from oxygen.
101. She felt panic.
102. The fear of not being able to breathe and having to have the windows open left after reliving that memory.
103. She used to not be able to allow anyone to spray anything around her, like perfume or hair spray.
104. She would be in a tremendous state of panic.
105. She felt she wouldn't be able to breathe.

Clustering Units of Relevant Meaning

Cluster headings for relevant meaning units are then formed for each protocol by sorting like units into clusters under descriptive headings. Table 2 lists the headings for each of the co-researchers.

Table 2

Cluster Headings for the Units of Relevant Meaning
From Each Protocol

- Marisa

An Experience of Herself as a Soul
The Light of Healing, Compassion, and Love
Feeling the Wrongness of the Conception
A Strong Light and Purpose
Struggling to Implant in a Toxic Womb
Discovering Another Being
Loving and Desperately Caring for Her Twin
Getting Bigger While Her Sister Became Sicker and Died
An Enormous Crushing Loss
Feeling Life Endangered as She Hung Out in a Toxic Womb
Knowing that Her Mother Did Not Want to be a Mother
A Devastating Memory of Her Own Suicide Attempt
Gaining a Deep Understanding of Her Daughter's Suffering
Feeling That Her Mother Was Trying to Kill Her in a Passive Way
Feeling Sad and Unwanted
Trying to be Quiet and Good so Mother Would Love Her
Becoming Intolerant of the Environment and Initiating
the Birthing Process
The Labor Was Difficult and Long
Mother Doesn't Want to Feel Anything and Is Knocked Out
Struggling to Be Born Without Mother's Help
Anger and Rage at the Doctor
Feeling Wet and Cold and Silent After the Birth
Longing for Love From Her Mother
Longing for Love From Her Father
Her Mother Still Won't Hold Her
Knowing That the Nurse Felt Her Mother Was Wrong

- Douglas

Almost Dying at Birth and How Excruciating It Was
Knowing He Had a Mother Who Couldn't Connect With Him
Realizing His Mother Didn't Want Him
Feeling Impregnated With His Mother's Grief
Feeling the Pressure of Forceps, and the Numbing of
the Anesthesia
Intense Pressure, Intense Rage, and Blacking Out
Feelings of Pressure, Fighting, Struggling, and Rage
Because He Was Trying to be Born and Mother Was
Clamping Down

Shaking, Crying, and Terror at Being Thrown by His Father
A Tremendous Sense of Relief
Feeling Terror, Vertigo, and Out of Control at Being
Held Upside Down and Spanked
Pushing and Straining to Get Out
Seizing, and Feeling Like Someone Was Stabbing a Knife
Into His Brain at the Memory of Forceps
Angry at the Struggle and Pain
A Sense of the Body Moving on Its Own

- Karlton

Feeling Tired, Zoned Out, and Strong Head Pressure
A Sense of the Body Moving on Its Own
Feeling Stuck for a Long Time with Pressure, Pain,
Heat, Anxiety, and Suffocation
Pressure So Strong That His Head Felt Rubbery, Like
Plastic. It Felt Like His Brain Was Being Mashed from
the Inside; Like His Head Was Caving In
Feeling Overtaken by the Experience
Little, Helpless, Scared, Stuck
Alone, Scared, in Pain, Crying
Enormous Crushing Pain
Defeated
Feeling Like He Was Dying
Struggling Like Crazy, Internally
Movement, Change, Relief
Suffocation
Crying, Crying, Crying
Really, Really, Really Blurry Vision
Panic

- Caroline

Her Body Resolved the Trauma.
Remembering That Her Mother Wanted a Boy
Born With the Feeling of a Broken Heart
Feeling Like a Great Weight Was Being Lifted Off Her Chest
Feeling Squished, Squashed, Suffocated, Panicked,
and Like She Was Dying
Anger and Fury at Being Slowed Down by Anesthesia
Feeling Her Body Untwisting and Freeing Up
Suffering With the Fear of Poisoning
Convulsions and Shock While Receiving the Wrong
Blood
Her Fear of Food Went away

Feeling the Pain of the Knife While Remembering
Surgery Without Anesthesia
Leaving her Body to Avoid the Pain
Panic and Suffocation
Feeling Pressure, Panic, and Cut Off From Oxygen
While She Remembered
Her Parents Having Sex While She Was In Utero
Perceiving a Disregard for Her Welfare
The Fear of Suffocation Left

- Rachel

Anger and Rage at Being Conceived in a Rape
Feeling Her Parents Anger
Struggling to Implant in a Toxic Womb
On the Verge of a Grand Mal Asthma Attack
Feeling Trapped in the Experience
Worsening Feelings of Being Trapped, Crushed,
Suffocating, and Dying
Feeling the Asthma Break
The First Deep, Clean Breath in Her Life
Still Feeling Trapped and Stuck but Being Able to
Breathe
Feeling as Though She Must Stay Huge to Avoid Being
Crushed
Feeling Beat Up, Crushed, Pummeled, and Hurt All Over
Exhausted and Alone
Depressed, Sad, and Angry
Suffocation

- Amy

Waking in the Fetal Position in Excruciating Pain
Experiencing Pain so Bad She Felt She Would Die
Feeling Trapped in the Experience
A Sense of Abandonment and Betrayal
Opening to the Feelings She and Her Mother Felt When
She Was in Utero
This Time She Really Got It
She Was Reliving the Whole Experience

- Jesse

Feeling the Pain of Being Hit in Utero
Sensing His Father's Anger and His Mother's Resentment
An Incredible Release of Energy Through Crying

Uncontrollably
Releasing the Energy Around the Third Trimester
Violence

Determining Individual Themes From Cluster Headings

Another grouping of the data occurs at this point which renders the individual themes. They are developed from the cluster headings of each protocol by combining those headings very similar in meaning under descriptive headings or themes. Each co-researcher will then have a list of individual themes.

The Zigzag Process

A procedure, known as the "zigzag" process, of going back and forth between the units of relevant meaning and the cluster headings, or the individual themes and the cluster headings or back to the text itself was introduced in order to assure that each theme was consistent with and inclusive of all of the meaning units of which it was comprised. To exemplify the zigzag process I have selected a few clusters of relevant meaning units for Caroline's protocol and listed them under their headings in Table 3a. Since most of her meaning units fell under the theme of Anguished Emotional, Physical, and Feeling States, I chose that theme for demonstration. I did not include all of the actual clusters used to develop that theme.

In order to pass the zigzag trial, the units of relevant meaning should resonate with the cluster heading that they are listed under (Table 3a). Then, checking with the listings in the following table (Table 3b), the cluster headings should share a very close meaning with the individual themes.

Table 3a

A Selection of Caroline's Clusters of Relevant Meaning
With Their Headings

I. Feeling Squished, Squashed, Suffocated, Panicked,
and Like She Was Dying.

- She had at least 12 sessions with Dr. C. where she felt like she was being squished and squashed coming out of the birth canal.
- She could not breathe.
- There was a great deal of panic.
- There was a great deal of feeling of dying.

II. Anger and Fury at Being Slowed Down by Anesthesia

- There was anger.
- The anger came from the fact that she was doing well until her mother took a drug so she wouldn't feel the labor.
- The drug slowed her down.
- She was unable to move.
- This infuriated her.

III. Feeling Her Body Untwisting and Freeing Up

- She felt a great deal of untwisting and freeing up taking place in her body.

IV. Convulsions and Shock While Remembering Surgery Without Anesthesia

- One day Dr. C. and she regressed her to just after her birth when she was receiving a transfusion.
- She was an unexpected Rh. baby.
- The first transfusion was the wrong blood.
- Her body went into complete shock.
- For about 30 minutes she convulsed as she had this memory.

Table 3b

Two Individual Themes Developed From a Sample of Caroline's Cluster Headings

Cluster Headings	Individual Themes
I. Feeling Squished, Squashed, Suffocated, Panicked, Anguished Emotional, and Like She Was Dying.	

Physical, and Feeling States

II. Anger and Fury at Being Slowed Down by Anesthesia.

IV. Convulsions and Shock While Receiving the Wrong Blood.

III. Feeling Her Body Untwisting and Freeing Up. Relief or Healing

It seems clear that Cluster Heading III is not consistent with the theme of Anguished Emotional, Physical, and Feeling States, rather it belongs under the theme of Relief or Healing. The zigzag procedure is utilized to verify these associations.

Table 4 demonstrates again how cluster headings are used to develop themes, by listing all of the individual themes for each co-researcher with the cluster headings that define them.

Table 4

All Individual Themes With the Cluster Headings That Comprise Them

Anguished Emotional, Physical, and Feeling States

Marisa

- Feeling the Wrongness of the Conception
- Struggling to Implant in a Toxic Womb
- Getting Bigger While Her Sister Became Sicker and Died
- An Enormous Crushing Loss
- Feeling Life Endangered as She Hung Out in a Toxic Womb
- A Devastating Memory of Her Own Suicide Attempt
- Feeling Sad and Unwanted
- Trying to be Quiet and Good so Mother Would Love Her
- Becoming Intolerant of the Environment and Initiating the Birthing Process
- The Labor Was Difficult and Long
- Mother Doesn’t Want to Feel Anything and Is Knocked Out
- Struggling to Be Born Without Mother’s Help
- Anger and Rage at the Doctor

- Feeling Wet and Cold and Silent After the Birth
- Longing for Love From Her Mother
- Longing for Love From Her Father

Douglas

- Almost Dying at Birth and How Excruciating It Was
- Feeling Impregnated With His Mother's Grief
- Feeling the Pressure of Forceps, and the Numbing of the Anesthesia
- Intense Pressure, Intense Rage, and Blacking Out
- Feelings of Pressure, Fighting, Struggling, and Rage Because He Was Trying to be Born and Mother Was Clamping Down
- Shaking, Crying, and Terror at Being Thrown by His Father
- Feeling Terror, Vertigo, and Out of Control at Being Held Upside Down and Spanked
- Pushing and Straining to Get Out
- Seizing, and Feeling Like Someone Was Stabbing a Knife Into His Brain at the Memory of Forceps
- Angry at the Struggle and Pain

Karlton

- Feeling Tired, Zoned Out and Strong Head Pressure
- Feeling Stuck for a Long Time With Pressure, Pain, Heat, Anxiety, and Suffocation
- Pressure So Strong That His Head Felt Rubbery, Like Plastic. It Felt Like His Brain Was Being Mashed From the Inside; Like His Head Was Caving In
- Little, Helpless, Scared, Stuck
- Alone, Scared, in Pain, Crying
- Enormous Crushing Pain
- Defeated
- Feeling Like He Was Dying
- Struggling Like Crazy, Internally
- Suffocation
- Crying, Crying, Crying
- Really, Really, Really Blurry Vision
- Panic

Caroline

- Born With the Feeling of a Broken Heart
- Feeling Squished, Squashed, Suffocated, Panicked, and Like She Was Dying
- Anger and Fury at Being Slowed Down by Anesthesia
- Suffering With the Fear of Poisoning
- Convulsions and Shock While Receiving the Wrong Blood
- Feeling the Pain of the Knife While Remembering Surgery Without Anesthesia
- Panic and Suffocation
- Feeling Pressure, Panic, and Cut Off From Oxygen While She Remembered Her Parents Having Sex While She Was In Utero

Rachel

- Anger and Rage at Being Conceived in a Rape
- Struggling to Implant in a Toxic Womb
- On the Verge of a Grand Mal Asthma Attack
- Worsening Feelings of Being Trapped, Crushed, Suffocating, and Dying
- Still Feeling Trapped and Stuck but Being Able to Breathe
- Feeling as Though She Must Stay Huge to Avoid Being Crushed
- Feeling Beat Up, Crushed, Pummeled, and Hurt All Over
- Exhausted and Alone
- Depressed, Sad, and Angry
- Suffocation

Amy

- Waking in the Fetal Position in Excruciating Pain
- Experiencing Pain so Bad She Felt She Would Die
- A Sense of Abandonment and Betrayal

Jesse

- Feeling the Pain of Being Hit in Utero

The Perception of Mother's or Others' Reality

Marisa

- Discovering Another Being
- Knowing that Her Mother Did Not Want to be a Mother
- Feeling That Her Mother Was Trying to Kill Her in a Passive Way
- Her Mother Still Won't Hold Her

Douglas

- Knowing He Had a Mother Who Couldn't Connect With Him
- Realizing His Mother Didn't Want Him

Caroline

- Remembering That Her Mother Wanted a Boy
- Perceiving a Disregard for Her Welfare

Rachel

- Sensing Her Parents Anger

Amy

- Opening to the Feelings She and Her Mother Felt When She Was in Utero

Jesse

- Sensing His Father's Anger and His Mother's Resentment

Relief or Healing

Marisa

- Feeling Validated by the Nurse
- Gaining a Deep Understanding of Her Daughter's Suffering

Douglas

- A Tremendous Sense of Relief

Karlton

- Movement, Change, Relief

Caroline

- Her Body Resolved the Trauma
- Feeling like a Great Weight Was Being Lifted Off of Her Chest
- Feeling Her Body Untwisting and Freeing up
- Her Fear of Food Went Away
- The Fear of Suffocation Left

Rachel

- Feeling the Asthma Break
- The First Deep, Clean Breath in Her Life

Amy

- This Time She Really Got It
- She Was Reliving the Whole Experience

Jesse

- An Incredible Release of Energy Through Crying Uncontrollably
- Releasing the Energy Around the Third Trimester Violence

Consciousness as Separate From the Body

Marisa

- An Experience of Herself as a Soul

Douglas

- A Sense of the Body Moving on Its Own

Karlton

- A Sense of the Body Moving on Its Own

Caroline

- Leaving her Body to Avoid the Pain

Feeling Overtaken or Trapped by the Experience Itself

Karlton

- Feeling Overtaken by the Experience

Rachel

- Feeling Trapped in the Experience

Amy

- Feeling Trapped in the Experience

The Light of Healing, Compassion and Love

Marisa

- The Light of Healing, Compassion, and Love
- A Strong Light and Purpose

Loving and Losing a Twin

Marisa

- Loving and Desperately Caring for Her Twin
- Getting Bigger While Her Sister Became Sicker and Died
- An Enormous, Crushing Loss

Seven individual themes emerged from the data which are used to describe the underlying structure of the experience being investigated. Two of those themes, Anguished Emotional, Physical, and Feeling States, and Relief or Healing were found in all seven protocols. The individual themes developed from each of the seven life-texts are shown in Table 5.

Table 5

All Individual Themes From Each Protocol

- Marisa
  Anguished Emotional, Physical, and Feeling States
  Relief or Healing
  The Perception of Mother's or Others' Reality
  Consciousness as Separate From the Body
  The Light of Healing, Compassion, and Love
  Loving and Losing Her Twin
- Douglas
  Anguished Emotional, Physical, and Feeling States
  Relief or Healing
  The Perception of Mother's or Others' Reality
  Consciousness as Separate From the Body
- Karlton
  Anguished Emotional, Physical, and Feeling States
  Relief or Healing
  Consciousness as Separate From the Body
  Feeling Overtaken or Trapped by the Experience Itself
- Caroline
  Anguished Emotional, Physical, and Feeling States
  Relief or Healing
  The Perception of Mother's or Others' Reality
  Consciousness as Separate From the Body
- Rachel
  Anguished Emotional, Physical, and Feeling States
  Relief or Healing
  The Perception of Mother's or Others' Reality
  Feeling Overtaken or Trapped by the Experience Itself
- Amy
  Anguished Emotional, Physical and Feeling States
  Relief or Healing
  The Perception of Mother's or Others' Reality
  Feeling Overtaken or Trapped by the Experience Itself
- Jesse
  Anguished Emotional, Physical, and Feeling States

Relief or Healing The Perception of Mother's or Others' Reality

General and Unique Themes

Two general themes emerged from the reduction of the individual themes. That is, individual themes with a

common essence were grouped beneath descriptive headings. All seven co-researchers expressed experience consistent with both general themes. The first general theme, A Range of Intensely Felt, Mostly Negative, Emotional, Physical, and Feeling States, is essentially self-explanatory. Just as each of the co-researchers was motivated to explore the pre- and perinatal realm by a painful condition(s), the alleviation of these conditions involved a painful reexperience. Many types of negative and a few positive experiences were reported, constituting this general theme.

Transpersonal Experience, the second general theme, was also reported by all the co-researchers. The remembrance of the pre- and perinatal realm in any form can be called transpersonal by virtue of it being an "expansion or extension of individual consciousness beyond the usual ego boundaries and limitations of time and space," (Grof, 1973, p. 35), and an extraordinary human experience (Sutich, 1969). However, the individual themes fitting precisely under the general theme of Transpersonal Experience include: The Perception of Mother's and Others' Reality, as an example of extra-sensory experience or clairvoyance; Consciousness as Separate From the Body, reflecting out-of-body experience (Grof, 1972, 1973); Feeling Overtaken or Trapped by the Experience Itself; The Light of Healing, Compassion, and Love; and Loving and Losing a Twin, by virtue of the fact that the memory was of an experience occurring at the cellular level.

The themes of The Light of Healing, Compassion, and Love, and Loving and Losing a Twin have been categorized as unique themes as they were reported by one co-researcher only. However, they also have a place among the transpersonal. The individual, general, and unique themes are listed in Table 6.

Table 6
Final Individual, General, and Unique Themes

Individual Themes for All Co-Researchers
Numbers of Co-Researchers

1. Anguished Emotional, Physical, and Feeling States (7) 100%
2. Relief or Healing (7) 100%

3. The Perception of Mother's or Others' Reality.(6) 86%
4. Consciousness as Separate From the Body.(4) 57%
5. Feeling Overtaken or Trapped by the Experience Itself .(3) 43%
6. The Light of Healing, Compassion, and Love (1) 14%
7. Loving and Losing a Twin (1) 14%

General Themes

Numbers of Co-Researchers
(Themes valid for all co-researchers)

1. A Range of Intensely Felt, Mostly Negative, Emotional, Physical or Feeling States.(7) 100%
2. Transpersonal Experience .(7) 100%

Unique Themes

Numbers of Co-Researchers
(Themes valid for only one co-researcher)

1. The Light of Healing, Compassion, and Love (1) Marisa
2. Loving and Losing a Twin(1) Marisa

Summaries

According to Hycner's guidelines, the next steps in the data analysis consist of writing summaries that incorporate the themes of the protocols for each of the seven participants, and then to return to the co-researchers for feedback. This researcher composed the summaries, obtained the suggested feedback, and made the necessary modifications. They were widely accepted and appreciated by the participants. The summaries with corresponding themes can be found in Appendix J.

Individual Themes in Context

The seven individual themes contain the essence of

the experience of healing through the remembrance of the pre- and perinatal. They are prereflective in the sense that they are as nearly as possible subjective expressions of experience prior to intellectualization. Hermeneutics, or the methodological principles of phenomenology, provided a procedure to explicate the underlying, subjective, structure of the experience in focus, while keeping it in tact.

Hycner suggests that the next step in the process of analysis is to contextualize the individual themes. The following lists the individual themes with representative samples of text from each of the seven protocols.

Anguished Emotional, Physical, and Feeling States

All of the co-researchers in this study expressed their experience of healing through the remembrance of the pre- and perinatal in painful terms. In fact, the word “pain” or “painful” was used 62 times in all of the life-texts combined. “Excruciating” was mentioned 11 times, “crushed” or “crushing” 19 times, “pressure” 32 times, “terror” 12 times, and “panic” 14 times. In general, there was a mixture of negative emotional, physical, and feeling states expressed by each of the co-researchers. Following are some excerpts from the protocols as examples of this theme:

- Marisa

And so I worked down the fallopian tube in the dark feeling terrified about what this ride was gonna be like. And dropping into the womb there was immediately a sense of darkness.

- Douglas

And it was the feeling of being born and having my head crushed and having so much pressure on my entire body from my mother just clamping down that I would fight and fight, struggle and struggle, and try to push. And I would be in a rage trying to get out cause she wasn't helping me. And the intense pressure along with the intense rage I was having then I would black out. It would finally get too much for my nervous system and I would just black out.

- Karlton

And it actually felt not only like my head was kinda caving in, but it even felt like my brain was getting mashed on the inside. But I felt a lot of pain. I felt really alone. Really scared. I started crying. And I couldn't breathe. I had really stuffed lungs. I felt like I was going to suffocate. And my vision was really, really, really blurry.

- Caroline

...they would cut me without anesthetic. ...But when Dr. C. put me under for that I felt the pain of the knife. ...I could actually feel the pain as though I was there having surgery without the anesthetic.

- Rachel

And I started just screaming out again, "No!" And I remember at one point I rolled over somehow, on my right shoulder and my neck, and I couldn't breathe. I was totally, I felt totally crushed and totally trapped. And I really, I just went ballistic. I really lost it at that point. I'd been hysterical before but it was a new level of hysteria.

- Amy

...I would wake up in the middle of the night, about one or 1 or 1:30 or so
in the morning, in excruciating pain. And I would be curled up in the fetal
position. And I was in so much pain I literally thought that I was going to die.

- Jesse

And the second he said "The 3rd trimester of pregnancy?," I had pain on my whole right side. My whole right side went to pain.

Relief or Healing

As with the theme of Anguished Emotional, Physical, and Feeling States, this theme was expressed by all seven co-researchers, but to a much lesser degree. In spite of the fact that all the participants were of the opinion that the remembrance of the pre- and perinatal was healing for them, what might be called "positive" expression was rarely seen. In his Basic Perinatal Matrix IV (BPM IV), Grof (1985) describes the culmination of the birthing process (clinical stage 3) in glowing, triumphant terms. Immense relief from the pressure, pain, and suffocation of the birthing process, and the feelings of victory over a life and death struggle to be born so often spoken of by Grof were not demonstrated by the co-researchers in this study. Perhaps the trauma experienced by those who can demonstrate symptom alleviation upon the remembrance of birth is so great as to overshadow the joy. Nonetheless, there are brief mentions of relief, sometimes interwoven with expressions of feeling healed. To illustrate the theme, all of the expressions of Relief or Healing within the seven life-texts are shown below.

- Marisa

I remember feeling that the nurse had a judgment about that [her mother not wanting to hold her] and felt that I was in for a rough time. And it helped that the nurse had some feelings about my mother's behavior.

- Douglas

...at that point I started connecting up my depression and sleepiness to being anesthetized and being chemically severed from my ability to fight the situation or flee from it due to going into dissociation and numbness. ...that was a big piece 'cause that helped relieve another chunk of the depression once I got that piece.

...I went into those feelings there on the bathroom floor of just like raging and blacking out, and then raging and then blacking out and then crying, crying and then raging and then blacking out and then crying

and just cycling through these feelings. ...then finally the raging and the crying went away.

...my body would be flipping and twisting and jumping. And so eventually I would feel through that piece and come out and the headache would be gone.

...this image of my father popped into my mind, of him grabbing me and throwing me across the room and me going backwards. ...I was flying through the air, thinking, "How am I going to land safely?" And so I felt that feeling and cried and shook and went through that. And then I just had this tremendous sense of relief after that.

- Karlton

...I moved forward and all these pressures changed again. And the way they were changing, my cranium changed. And then after that everything kind of popped and I kinda crawled forward a little bit. You know, felt some relief from the pressure.

- Caroline

I cried. And as I cried I felt like a great weight being lifted off my chest. And that was the physical response I had to uncovering the fact that my mother had wanted a boy instead of a girl.

And then I had at least 12 sessions with Dr. C where I felt squished and squashed coming out of the birth canal and could not breathe. And again I felt a great deal of untwisting taking place in my body. A lot of freeing up.

But I also had a pre-birth memory where my father was having sex with my mother shortly before I was born. And there was a pressure that was being applied there. There was no concern for my welfare. ...And the fear of not being able to breathe and having to have windows open left after reliving that memory.

And I used to not be able to allow anyone to spray anything around me, whether it was perfume, hair spray, anything like that. I'd be in a tremendous state of panic, feeling "Oh my God, I won't be able to breath!" But that disappeared also.

- Rachel

...at some point I started screaming. I just started howling. And it was like I took the first deep breath of my life. And it was, it was... my asthma broke and I took this deep breath that seemed to extend down to my toes. And I felt like I was breathing, that I had taken the first breath, the first deep clean breath that I had taken in my entire life. And when my asthma broke I knew at that moment, and I don't know why I knew it or how I knew it but I knew at that moment that I was never going to have asthma again the way I'd had it. That it was gone. All the wheezing stopped and all the coughing stopped and my lungs were clear. ...I could breathe again. It was very different. I could breathe. I was still stuck but I could breathe. And I knew that the whole asthma thing was gone.

- Amy

And I stayed in that position and stayed with the pain until I realized that absolutely everybody I'd ever been involved with had had an affair. But this time I really got it. It was like, "Oh my God!"

- Jesse

Some of it I just started blubbering, just an incredible release of energy, just started crying, crying uncontrollably.

And then we came back from...to the present, and saw that the illness, my back pain, was really associated with that [the 3rd trimester violence]. He acknowledged that and that I could now release that energy. And I did. And within a few hours the pain was mostly gone. And the next day totally gone never to return.

A Perception of Mother's or Others' Reality

The data giving rise to this theme illuminates what Wade (1996) describes as "transcendent consciousness." It is that form of consciousness that is mature and

not attached to the fetal body. It is, as such, the conscious and transpersonal awareness of the feelings of mother or others. Six of the seven co- researchers expressed this ability. The following is a sampling.

- Marisa

But anyway, she went to the doctor and found out she was pregnant. And on the way back she was standing by this streetcar line and thought about it and almost did throw herself under the streetcar. And I just felt really awful that my mother would prefer to die rather than have me. And I never got over that.

She told the doctor, and I remember this...I remember his white coat. That she didn't want to feel anything. And she wanted him to knock her out. And when the baby was born she wanted somebody to tell her if it had the right number of fingers and toes and that was all she cared about.

- Douglas

The other thing that was really profound when I was at that ranch was connecting to the memory of being in utero and realizing my mother didn't want me.

- Caroline

But I also had a pre-birth memory where my father was having sex with my mother shortly before I was born. And there was a pressure that was being applied there. There was no concern for my welfare. And it was probably what you would call "rough sex".

- Rachel

Barbara asked me to remember or asked what it felt like at the moment of my conception. And I immediately felt rage. I guess my face got all red. And, I felt that I had been conceived in a rape. And I thought that both my parents were very angry.

- Amy

...what happened was that during the time of this pain I just kept opening up to the feelings of being abandoned and being betrayed that I think both my mother felt and I felt when I was in utero.

- Jesse

Well my dad has just hit my mother in the stomach.

Consciousness as Separate From the Body

Four of the co-researchers expressed the remembrance of experiencing themselves as entities without or separated from their bodies. While Marisa told of her joyful recollection as a soul prior to birth, Douglas and Caroline associated the separation from their bodies with extreme pain. Karlton recalled the perception of his body reenacting birth, with an innate knowledge or memory, and without him willing it to do so. The common thread for all of these remembrances is a sense of the self as disembodied. Following is the original text giving rise to this theme for Marisa, Douglas, Karlton, and Caroline.

- Marisa

I had had an experience of myself as a soul prior to birth. Hanging out in the universe. And my recollection is almost a visual one of hanging out in a little egg of light out in the midnight blue sky. Stars all around. And I felt very safe and warm and sure of my purpose in coming to earth. I knew I was going to come to earth.

- Douglas

I would slowly return to consciousness and it was like my consciousness started noticing that I had a body and that I was there but my body was jerking and twisting and flopping around all by itself. ...And the pain would get so intense I would black out. And then I would start coming back to consciousness. And then my body would be flipping and twisting and jumping.

- Karlton

But I felt my body starting to push forward. I mean I wasn't even asking it to do this. My body just started doing this by itself. And it felt like, not even so much like a memory, but more like a reenactment. Like my body was just doing something it had done before.

- Caroline

... because this was done so many times on my body... was to learn at that point in my life to leave my body. It was very easy for me to leave my body from that point on. Because I was being cut quite a bit.

It was horrible. They cut my feet first. When I started feeling the second cut that's when I started feeling...I said, "Oh gee I'm feeling real goofy. I don't feel pain anymore. I feel like I'm light and I'm floating up."

Feeling Overtaken or Trapped by the Experience Itself

Some of the participants spoke of the experience of the remembrance of the pre- and perinatal as if it had a life of its own. They seemed to feel as though once begun, the experience gained momentum, and they lost control over it. These quotes represent all references to this phenomenon.

- Karlton

I wasn't even trying. I was like so totally into the experience that it was like guiding me, making my body do it. ...it wasn't like a particular suggestion or anything. William got everything started but it was like this whole thing took over.

- Rachel

I felt trapped. I didn't feel like I had an option. I mean I felt like I was trapped in this experience. And that's just the way it was, actually. I didn't really think about it in any objective sense that I could stop the experience or you know, quit in any fashion.

- Amy

I just found myself in this position and there wasn't really any way I could get out of it, you know?

The Light of Healing, Compassion, and Love

This is one of two themes unique to the current study, both expressed by Marisa. It is unique because among all seven life-texts, it is the only direct reference to the spiritual aspects of the pre- and perinatal.

- Marisa

And I felt very safe and warm and sure of my purpose in coming to earth. I knew I was going to come to earth. And the purpose was a small one but it meant a lot to me. And that was to bring light to the earth. Light of healing, compassion and love. It's not anything big and grandiose. I didn't suspect I was going to be known by anybody or anything like that. I would give this gift to a few people.

And so they did come together and I guess my light and my purpose were strong enough to make it take...to make the two come together and form one.

Loving and Losing a Twin

Marisa's remembrance of the death of her twin sister shortly after conception lends support to the poetic work of Vlcek (1993) describing his recollections of embryonic experience. The theme also can be seen as an example of the concept of cellular consciousness as Farrant (1987) and Larimore and Farrant (1997) might describe it. Noble (1993), LaGoy (1993a & b), and Diamond (1992) have written about the frequency of multiple pregnancies, with Noble and LaGoy emphasizing the tragic circumstances surrounding in utero sibling loss.

- Marisa

And after a while I became aware of another being with me. And I moved over enough so I could see her and I was really glad to know she was there. I found out

quickly that she was even weaker and more scared than I was. She was really having a hard time...staying alive. And as we continued to grow I was just totally in love with her. And I felt desperately that I needed to take less to give her more. And I tried to do that but nevertheless I got bigger and she...she just got sicker. And eventually she died and kind of fell away from me. And I have a strong visual of that as being this totally heartbreaking moment. And I felt this enormous crushing loss. It was just devastating.

Composite Summary

The last step in the Hycner process is to write a composite summary from all the protocols hypothesizing what the experience in question might be like for the "representative composite subject." The following is my impression of the journey that could be facing a participant of this study.

The representative composite subject may enter into the realm of the pre- and perinatal with the hope of alleviating painful physical or psychospiritual conditions. The entrance could have been planned ahead of time, or be spontaneous, with no warning. Sometimes the subject will remember being conceived under the influence of violence and alcohol, and then implanting in a polluted womb environment that resembles a sewer. Or they may recall being a developing fetus in the third trimester remembering their mother's emotional trauma, or even a physical assault. They might even wake in the middle of the night, finding themselves in a prenatal drama.

Sometimes they know how their parents feel about them. That is, they may know that they were not wanted. At the same time, they may feel tiny, helpless, and at the mercy of their mother and involved others. They often have emotions, likes, dislikes, and opinions. They are sensitive and intuitive, and sometimes feel steeped in mother's feelings, like grief or fear. They can be aware of the medical atmosphere, and staff attitudes.

Whether the remembrance is of conception, implantation, gestation, or birth, foremost, is the issue of survival. This is because these monumental events can involve life or death struggles, especially for those who have been traumatized. Those who have

come face-to- face with the remembrance of a pre-or perinatal trauma, like attempted abortion, asphyxiation, anesthesia, the loss of a twin, the inability to implant, battery, or feeling unwanted can attest to the inherent danger involved. The reexperience of an emotional or physical trauma may reflect a heavy blow to the neonate. For example, the representative composite subject could remember a broken heart at birth which they had been manifesting as chest pain the whole of their life. Or, they could remember convulsing from the shock of being transfused with the wrong type of blood. They might recall an assault in the third trimester of life only to discover they had been expressing the injury as an adult in an obscure physical condition. Attachment to their intrauterine twin could be the image the co-researcher recovers, only to be faced with the memory of that twin's demise.

Even when essential, medical intervention viewed retrospectively by the representative participant is not appreciated. This recollection could show that anesthesia hits a birthing neonate as an enormous impediment to navigating an already precarious situation. Not only are they slowed down by the drug, but Mother does not help much after that. Likewise, one who remembers the pain of forceps may feel intense rage at the insult to their birthing process. Or, they may blackout, or feel the total loss of control of remembering being hung upside down and spanked. Imagine if you can surgery without anesthetic. Could anything be more horrifying? Medical intervention is bound to be painful if not dangerous.

The need for a close maternal relationship is paramount. The representative co-researcher in this study usually treasures and longs for such maternal connection before and after birth. If they can’t have Mother, they may attempt to bond with others. But very little bonding of any kind occurs for these co-researchers. Most will have very strained parental contact, if they have contact at all.

The representative co-researcher might be fortunate enough to enjoy the pre-conception recollection of life as spirit. It could be very pleasant to recall making plans for an upcoming life, floating about in the heavens in a little shell of light, and watching the stars. Remembering one's good intentions and their

still tangible connection with the world of spirit could lend strength for what will most assuredly be a perilous journey. But, for the prototypical co-researcher, remembering the birthing process might entail feelings of being crushed, mashed, squashed, suffocated, pummeled, beaten, killed, or completely overcome. This person might have a memory of their head feeling rubbery, like plastic, or like their brains were being mashed from the inside, or like their head was caving in. They might recall having felt pain as if someone were pushing knives into their brains. Perhaps they will remember the sense of their body taking over, being overtaken by the experience itself, or just leaving their body completely. In fact, memories of feeling as though one were being killed, or of wanting to die, are not unusual.

In the phenomenological study of healing through the pre- and perinatal the participant does get the healing they have hoped for, perhaps beyond their wildest notion. Assuming that the condition(s) they want to affect are actually related to a trauma that took place sometime during the pre- and perinatal period of their life, they can use birth regression to affect changes in many areas. They can ameliorate or cure conditions such as: arthritis, depression, suicidality, visual impairment, phobias, back/side pain, migraine headache, blackouts, obsessive compulsions, interpersonal relationship dysfunction, asthma, and others. They may also develop personal, psychological tools to use in self-support, and self-empowerment. This co-researcher will probably feel better about life in general.

The healing experience, however, comes at a premium. Little of a positive nature is recalled by the representative co-researcher. For, while they are attempting to retrieve repressed memories, they must be prepared to feel the pain of the original trauma. They need courage, and a significant desire for wholeness to bypass the subconscious road blocks that await them in the journey through the remembrance of the pre- and perinatal.

The conclusion of the Composite Summary represents the completion of Hycner's Guidelines, and brings the researcher to the point of demonstrating the results of the current study outside the formalized methodological process. The rest of the chapter will

be devoted to this end. The following section underscores the healing that occurred as reported by the co-researchers.

Results of the Follow-up Question

Because the first and second interviews elicited mainly the recollection of intense pain and discomfort, and not the healing benefits, the need for the following question became apparent, What about your pre- and perinatal experience was healing for you? Asking the follow-up question gave the co-researchers an opportunity for a reflective expression of their experience. Highlights of each of the co-researchers' responses are next, followed by excerpts depicting indications of quality of life enhancement.

- Marisa

Gained insight into the origin of life-long, dysfunctional relationship patterns, depression, suicidality, addiction, attachment, and intimacy difficulties. Utilizes the insight to cope with life, and to relate to her daughter and others. Discovered a forgotten sense of divinity and purpose.

- Douglas

Eliminated conditions of migraine headaches, blackouts, and the obsession to pursue airborne gymnastic exercises. Alleviated feelings of loneliness, isolation, and depression. No longer pushes himself, and no longer feels the need to prove his worth to himself or others. Enjoys commercial piloting without panic.

- Karlton

Made a 28.5% improvement in the vision of both eyes. Feels that an even greater benefit was to gain self-empowerment by accessing deep, bodily information. According to Karlton, "I don't have to live my life the way I was born." That is, when pressured and under extreme stress, as in birth, he can maintain control, and exercise his options.

- Caroline

Healed herself of cibophobia (fear of food), toxicophobia (fear of poisoning), pnigerophobia (fear of being smothered), and chest pain. Obtained nearly complete alleviation of an arthritic condition which required confinement to a full back brace, from neck to tailbone. Resolved strong feelings of anger toward her mother after having held her responsible for the distress.

- Rachel

Mitigated “98%” of a life-long asthmatic condition, and the almost complete elimination of the medications used to treat it. States that her life is very different in that she can participate in physical activities she could not have engaged in before, such as hiking and other outdoor “stuff.” Feels that her immune system is functioning properly for the first time. Suffers from fewer colds and allergies.

- Amy

Gained awareness of a pattern of abandonment and betrayal that began in utero. Believes that through the awareness of her own history of perpetuating the pattern she is able to maintain a satisfying, monogamous, relationship. Integrates birth remembrance with career as a body therapist.

- Jesse

Achieved the complete elimination of a back/side pain condition that had eluded doctors, and required a 3 day hospitalization. More importantly, for Jesse, he obtained a level of forgiveness, or the alleviation of hatred toward his father.

An Enhanced Quality of Life

The interviewees demonstrate an impressive array of healing results reporting feeling healed on spiritual, emotional and physical levels. While the alleviation of symptoms occurring on the physical plane, such as

Douglas's cure of migraine headaches and syncope and Caroline's mitigation of arthritis, the psychospiritual healing that occurred is also noteworthy. In spite of the extremely difficult and painful memories related by the co-researchers, the impression given in response to the follow-up question points to an overall improvement in the quality of their lives. Excerpts from the transcripts to that effect follow.

- Marisa

Well it's been healing primarily because I learned about the beginnings of a number of life-long patterns that I had repeated over and over again. ...And another thing is Kind of life-long depression. That comes from feeling like I'm not...there's something wrong with me because I wasn't wanted. Now it's more habit and thought than anything else. ...But when I catch myself I can say, "Oh it's that again." And I can get out of this feeling of hopelessness and wrongness a lot easier.

..And I gained a spiritual awareness of my purpose through this work. And of my light, my holiness.... that has been a tremendous help to me.

- Douglas

...my depression is probably 95% gone...I'm finding myself able to relate a lot more to my own feelings and people in general. I don't feel nearly as isolated and lonely as I used to feel. ...the obsession I had to twist and float is also gone. And now I'm a pilot, and not a "white knuckle" pilot! I really enjoy it without the panic. And I don't push myself. I push myself about 80% less than I used to. I'm a lot easier on myself. I don't need as much to prove I'm okay.

- Karlton

...it's about becoming more aware or more conscious I guess you could say of how I respond to the world. The healing was more than just the eyes changing. It's knowing that I can learn things about myself I never thought were possible. And I just get really turned on by that.

- Caroline

Anger. I healed a lot of anger that I held toward my mother. 'Cause I held her responsible for my birth pain. And that's simply because the infant has no one else to blame; that's all they've known. And so I held her responsible. A lot of anger held at my mother I was able to let go of.

...birth affects us in ways that we can't even begin to imagine, until we take the courageous step into looking backwards to our beginnings. ...then the birth and the trauma that is created for us loses the control it has on our life.

- Rachel

...I can do stuff now that I couldn't do before. Because of the birth regression. I can do hiking, I mean I go slow, but I can do hiking and outdoor stuff that I couldn't even attempt before. So my life is real different as far as that is concerned.

- Amy

I cleared up a relationship pattern so now I don't have to deal with my partners having affairs anymore. You know that was pretty big.

- Jesse

More important than the pain was...I've always had this hatred for my dad. ...And it never would go away. And I used to be just driving in the car wishing he were dead. ...So the most healing that took place is that that totally went away. Not all the anger, but the wishing he were dead. So even more than the pain that went away in my side, the freedom that occurred there was incredible.

Results of the Demographics Form

Six of the seven co-researchers made reference in their protocols to domestic situations at risk for subsequent child abuse. A demographics form (see Appendix F) revealed worse domestic situations and birth conditions than had been relayed. Information gathered from the form and the interviews depict the following: all seven participants claimed emotional abuse, four had at least one alcoholic parent, four were sexually abused, four were physically abused, four had birth complications as reflected by forceps deliveries or transfusion, four felt unwanted, and three reported being physically abused. These and other negative domestic, birth, and childhood conditions can be seen in Tables 7 and 8.

Table 7
Birth and Domestic Situations Revealed by the Protocols and Demographics Form

Co-researcher	Situation
Marisa	Parental Alcoholism Unwanted Heavy Smokers Sibling With Illness Birth Complications
Douglas	Parental Rage Unwanted Poverty Previous Fetal Demise Birth Complications
Karlton	Parental Alcoholism Domestic Violence
Rachel	Heavy Smokers Chronic Depression Domestic Violence
Caroline	Parental Alcoholism Unwanted Domestic Violence Birth Complications

	Childhood Illness Heavy Smokers
Amy	Parental Alcoholism Conception out of Wedlock Unwanted Birth Complications
Jesse	Domestic Violence Physical Assault in utero

Table 8

Types of Child Abuse Identified by the Co-researchers

Co-researcher	Type of Child Abuse or Neglect
Marisa	Emotional Neglect
Douglas	Emotional Sexual Physical Neglect
Karlton	Emotional Sexual Physical
Rachel	Emotional Sexual Physical
Caroline	Emotional Sexual Physical Medical
Amy	Emotional
Jesse	Emotional

Upon discussion of this outcome with several of the co-researchers and others, the following speculations about the high incidence of child abuse among the

co-researchers have come to light:

- Negative domestic conditions such as substance abuse, domestic violence, poverty, unplanned pregnancy, conception out of wedlock, and sexual abuse were occurring prior to conception through birth. This may reflect the dysfunctionality of the parental personalities. Further, the lack of parental participation and enthusiasm in the pregnancies and births may have resulted in greater anesthetic usage, prolonged labor, feelings of being unwanted, unloved, and having to conduct the labor alone. In these cases, pre- and perinatal trauma and subsequent child abuse appear to be a consequence of unprepared, dysfunctional parents with medical intervention in the birthing process.

- Most people involved with birth regression therapies were previously involved in psychotherapy, and likely had early childhood issues to resolve at the outset.

- Children who have been traumatized at or before birth tend to be a trial for any parent due to the possibility of exhibiting symptoms similar to Post Traumatic Stress Disorder.

- A negative birth experience may lead to a negative life experience as the child attempts to work things through.

- The demonstration of symptom alleviation indicates a pre- and perinatal experience that was more traumatic than the usual, hence, drawing the victim into therapy and into view.

- Symptom-producing trauma at the pre- and perinatal stage may be more common than is generally believed. Related research is at the beginning stages.

- No one has really examined this subject before now.

- Children who suffer child abuse may have less well developed psychological defenses and may tend to more readily remember their births than normally treated children.

- This is too small a sample to draw definite conclusions, but indicates a need for future research.

Cartography of Inner Space

Although conjectural, these observations offer some understanding for the marked incidence of child abuse. Grof's (1985) theory of "systems of condensed experience" or COEX systems suggests other possibilities. The COEX system and BPMs represent part of Grof's (1985) "cartography of inner space." This organization consists of the following levels of mind: (a) the sensory barrier (a mostly visual field separating the individual from the unconscious realm); (b) the individual unconscious (biographical memory); (c) the level of birth and death (perinatal realm); and (d) the transpersonal domain (consciousness outside the realm of normal ego boundaries). The BPMs represent divisions of the perinatal realm which correspond to the clinical stages of childbirth. COEX systems combine similar circumstances, emotions, physical sensations, and related fantasy material on all the different levels of the psyche.

"Systems of Condensed Experience" (COEX)

On the biographical and perinatal level a COEX system may manifest as the continuity of similar circumstances, emotional tone, and other corresponding elements, whether all negative or all positive. If this pattern reaches into the transpersonal realm, corresponding past life or archetypal material could surface. About the COEX system Grof (1985) writes,

> ...a dynamic constellation of memories (and associated fantasy material) from different periods of the individual's life, [biographical, pre- and perinatal, and transpersonal] with the common denominator of a strong emotional charge of the same quality, intense physical sensation of the same kind, or the fact that they share some other important elements. (p. 97)

A continuity of emotion, feeling states, and experience can be identified between the recorded pre- and perinatal experiences and the biographical portions of the interviewees' lives. Douglas, for example, related pre- and perinatal experience with feelings of: being unwanted; anger, rage, and sorrow; having to drive himself; physical pain; and a continual fight for survival. No doubt, growing-up raised similar challenges and feelings for Douglas as

he dealt with emotional, sexual, and physical abuse, poverty, parental rage, and neglect. Further, he drove himself to endure the earlier emotions, physical suffering, and feeling states as he used primal therapy, gymnastics, and flight training to reexperience and heal his pre- and perinatal experience.

Caroline offers another reflection of a Grofian (1985) COEX system. Born with feelings of a broken heart, dying, panic, being overwhelmed by anesthetic, being unwanted, and enduring surgery without anesthetic, Caroline barely survived. Then growing up she faced living in an alcoholic household with domestic violence, crippling arthritis, and sexual, physical, and emotional abuse. Later, as she healed herself with hypnosis, she reexperienced the feelings of being unwanted, panic, dying, terror and everything that she had previously felt.

Negative Aspects of BPM I

BPM I can reflect idyllic as well as hellish conditions. It represents the union of fetus and mother prior to the onset of labor. Unless preceded by a negative conception experience there is generally a pleasant and natural symbiotic union. In this sense, the fetus has all needs met effortlessly and its life can be blissful. The negative aspects of BPM I can manifest, however, if physical, chemical, biological, or psychological aspects of uterine life deteriorate, or the size of the growing fetus becomes an issue (Grof, 1985, p. 102). Grof (1985) describes parts of BPM I in positive terms, such as, “During episodes of undisturbed life in the womb, the conditions of the child can be close to ideal” (p. 102). Marisa made only symbolic mention of such a state of well-being with a description of being, “a soul prior to birth.” Negative aspects of BPM I can be seen in the protocols of Marisa, Douglas, Caroline, Amy, and Jesse.

- Marisa

And dropping into the womb there was immediately a sense of darkness. A sort of goo-like gloppiness. ...And this image is like one I once saw of the inside of the lungs of a heavy smoker. And there was literally tar all around the little hairs, the cilia or whatever they're called that line the lungs making

them look, I don't know, like grasses in the sea that are polluted by an oil spill. And that was the image I had of what my mother's womb was like...that it was all black tarry stuff and it was almost impossible to see and to survive 'cause it really smelled bad, and tasted bad.

So I just hung out in the womb in a toxic environment. My feeling was that my mother was trying to kill me in a sort of passive way. So I was very, very sad and I just felt very strongly that I wasn't wanted. So I just tried to be very quiet and quote "good" unquote, so that maybe if I didn't cause her any problems she would love me. ...So then I continued to hang out in there and grow. And I never lost the sense of it being polluted and of my life being in danger. I was like...felt really assaulted.

- Douglas

The other thing that was really profound when I was at that ranch was connecting to the memory of being in utero and realizing my mother didn't want me. And then she was still in mourning about the loss of her first child but she had never mourned that child. So she was full of grief and I was marinating, as I was cellularly growing, in her grief. And it was almost as though it impregnated me with her grief and then also left me grieving because she didn't really want me she wanted a replacement for the other child. So she wasn't really looking for me. She wanted that other child to come back. And so it left me feeling unseen...unwelcome.

- Caroline

But I also had a pre-birth memory where my father was having sex with my mother shortly before I was born. And there was a pressure that was being applied there. There was no concern for my welfare. And it was probably what you would call "rough sex." And there was pressure applied on me. And I felt cut off from my oxygen and I was panicked inside the womb.

- Amy

...what happened was that during the time of this pain I just kept opening up to the feelings of being

abandoned and being betrayed ...I mean I really did think I was going to die. And my mother actually did try to abort me several times.

- Jesse

And the second he said, "The 3rd trimester of pregnancy?" I had pain on my whole right side. My whole right side went to pain. ..."Well my dad has just hit my mother in the stomach."

BPM II

BPM II coincides with clinical stage 1 of the birthing process in which labor has begun, muscular contractions occur in the uterus, but the cervix is closed. In one description of BPM II Grof (1985) writes, "...it attracts COEX systems with memories of situations in which the passive and helpless individual is subjected to, and victimized by an overwhelming destructive force with no chance of escaping" (p. 112). BPM II reflects the beginning of labor, a sense of victimization, or a feeling engulfment, which can be seen in these excerpts from the protocols of Marisa, Douglas, Karlton, and Rachel.

- Marisa

Finally at 7 1/2 months I really couldn't tolerate the environment anymore. And I just gathered all my energy to support this feeling that I had to get out of there. That was another feeling that's lasted all my life. And so I just really put an enormous amount of effort into trying to get born. It was my initiative and I started the process and kept trying to come out. And it was really, really difficult and really long...

- Douglas

And while I was there I recovered the memory of almost dying at my birth and remembering how excruciating it was. And how I almost died and wished I would die. Because it was so painful. And I remembered a 36 hour labor and feeling like I was being crushed to death....

- Karlton

I felt really little and really helpless and scared. And um, then I started feeling pressure on my right side of my head only down farther. ... And then I got stuck again for a long time. And then I started feeling like the whole world was caving in on me and I didn't know which way to go. I didn't know which way to turn. I didn't know how to move. And I just gave up for a long time. But then I started feeling like I was going to die. Like I couldn't move. And I got really scared.

- Rachel

... I felt trapped. I didn't feel like I had an option. I mean I felt like I was trapped in this experience...it was harder and harder to breathe and I was feeling more and more trapped. And I was feeling crushed. And that... that...like I was going to die. I really felt like I was going to die. And I remember starting to yell out or scream out, "No!" And at some point... And I was coughing and couldn't breathe. It seemed to be getting worse. And at some point I started screaming. I just started howling. ...I was feeling more and more trapped. And I started just screaming out again, "No!" And I remember at one point I rolled over somehow, on my right shoulder and my neck, and I couldn't breathe. I was totally, I felt totally crushed and totally trapped. And I really, I just went ballistic. I really lost it at that point. I'd been hysterical before but it was a new level of hysteria.

BPM III

BPM III coincides with clinical stage 2, in which contractions intensify but the cervix has dilated, perhaps giving the birthing infant a sense of there being a fighting chance for survival. BPM III, Grof (1985) writes, "...involves an enormous struggle for survival, crushing mechanical pressures, and often a high degree of anoxia and suffocation" (p. 116). Marisa, Douglas, and Karlton, describe parts of their experience in similar terms.

- Marisa

And so he did knock her out. I didn't get any help at all. And it was really, really, really hard. 'Cause I was poisoned and toxic to start out with and I was going on adrenaline, period. But you know a life and death struggle gives a person a certain amount of strength so I did persevere and continue to push. Finally, it seemed like even though she was drugged, I was drugged, and it was hopeless, I was making progress. And I was just about out of there.

- Douglas

And it was the feeling of being born and having my head crushed and having so much pressure on my entire body from my mother just clamping down that I would fight and fight, struggle and struggle, and try to push. And I would be in a rage trying to get out cause she wasn't helping me. And the intense pressure along with the intense rage I was having then I would black out. It would finally get too much for my nervous system and I would just black out. And so I went into those feelings there on the bathroom floor of just like raging and blacking out, and then raging and then blacking out and then crying, crying and then raging and then blacking out and then crying and just cycling through these feelings.

...I could go into the feelings and would invariably connect to a birth feeling...of pushing and pushing and straining to get out. And then having forceps clamping on my head. And the feeling I would go into when I would be having those feelings from the migraines is it felt like somebody was stabbing a knife into my brain. But it was just excruciatingly painful...and then I would black out. And then I would...like I would come out of the blackout and I would be like... sometimes my body would be like in a seizure. You know it would be jerking and twisting and stuff all by itself. I would slowly return to consciousness and it was like my consciousness started noticing that I had a body and that I was there but my body was jerking and twisting and flopping around all by itself. And of course that freaked me out too when I noticed that. And then what I would do is I would go

back into feeling. There was a part of me that was still... I was angry...I was just like straining...straining and pushing and angry. And then my head would be hurting like hell. And then it felt like somebody would be stabbing a knife into my brain...I mean in my brain...that's how it felt. And the pain would get so intense I would black out. And then I would start coming back to consciousness. And then my body would be flipping and twisting and jumping.

- Karlton

And I felt like I had to do something. And I just started struggling like crazy. But it was all like an internal struggle because I'm quite sure I wasn't flailing around. But it felt like I would have if I could have. But I couldn't, I couldn't....

BPM IV

Of BPM IV Grof (1985) writes, "...the agonizing process of the birth struggle comes to an end; the propulsion through the birth canal culminates and the extreme build-up of pain, tension, and sexual arousal is followed by a sudden relief and relaxation" (p. 122).

Correlating with clinical stage 3, or the actual moment of birth, a BPM IV experience is thought to be a joyous relief. This expression was not related by the co-researchers of the current study, except symbolically by Jesse. His images of being celebrated by his ancestors that he "broke the chain" and "had finally got it" is classic symbolism for those experiencing the moment of birth (Richard Tarnas, personal communication, May, 1999). The following are excerpts depicting the moment of birth and just afterward for Marisa, Douglas, and Rachel.

- Marisa

The next thing I remember is feeling these cold metal instruments grab around my head and pull on me. And it was so infuriating to me. I really wanted to just rip the doctor's head off. I've never felt such rage in my

life. When this came up in a birthwork session I felt like I could just rip the whole place down because I felt like my experience was taken away from me. And I had done all the work. And then I didn't even get to get born. This man just ripped off my triumph.

So then I was just on this white sheet or something with white lights, bright white lights. And I was wet and shivering. And I remember just lying there and being silent. I really wanted my mother to pick me up and comfort me after the ordeal I had been through. And I just desperately needed some human contact. She didn't pick me up. And she didn't say anything. And nobody said anything. And I was totally all alone there and I started to cry.

- Douglas

I also retrieved a memory of ...you know when I went on the floor one day...of being born and being held upside down and having that feeling of vertigo and just went, "Ahhhh! What's happening? What are you doing? Are you gonna drop me?" And so it was retrieving that memory of being held upside down at my birth where I was held upside down and spanked because I wasn't breathing. And so that was also entwined with that feeling of vertigo, being out of control, terrified. ...And the feeling again went into terror and then went into the memory of being held upside down. And how scary that was.

- Rachel

...I was just exhausted and that there was nobody there to help me get out but me. And that I sort of crawled my way out of the womb and uh I was just there. I was really depressed and sad and underneath, angry. It was awful.

Jesse's Experience of the Transpersonal

During the data analysis portion of this paper, it was decided that Jesse had actually veered away from the experience of pre- and perinatal remembrance, to the reporting or fantasizing of the experiences of other people, specifically, his ancestors. While

recognizing this as a leaning toward the transpersonal level of Grof's (1985) theories, I agreed with the decision to bracket portions of Jesse's protocol that pertained specifically to the pre- or prenatal and to include only the bracketed material with the data. However, during the writing of the final draft I began to feel that this was an error.

Grof (1975), in referring to ancestral memories, underscores Jesse's unusual experience, with the following, "The individual feels that his memory has transcended its usual limits and that he is in touch with information related to the life of his biological ancestors" (p. 162). Apparently, it is a fairly common experience to gain access to the transpersonal through the pre- and perinatal realm, and, as such, to experience ancestral memories (Richard Tarnas, personal communication, March, 1999). About varieties of transpersonal experience, Grof (1985) writes,

> ...they frequently appear to be tapping directly, without the mediation of the sensory organs, sources of information that are clearly outside of the conventionally defined range of the individual. They can involve conscious experience of other humans and ...history and prehistory... (p.127)

With comments from Grof and Tarnas explicitly recognizing experiences such as Jesse's as typically coming from the transpersonal through the perinatal, I decided these data should be included in the original analysis. However, I felt that it was much too late in the process to do a complete reanalysis. If I were to start over, however, I would include it.

It is impossible to say exactly what effect the exclusion of these data has had on the themes and overall results. The following, though, are my speculations. Perhaps a unique theme would have emerged since ancestral memories were not experienced by the other co-researchers. However, since eight out of ten of Jesse's memories were validated by his mother, it is safe to say that his experience fits comfortably under the general theme of Transpersonal Experience. The data coming from his bracketed protocol, the follow-up question, and the demographics form carries almost identical emotional tone, domestic and child abuse aspects, and quality of life enhancement as the rest of the interviewees. In the

final analysis, I do not believe that a reworking of the data with the inclusion of Jesse's transpersonal experience would have made a significant difference in the results of the study. The following is the excluded text.

Then he [Max, a friend who helped him with relaxed focused attention] did something really interesting. He asked me to just go around and step behind your dad and have the experience through his eyes. So I'd come into his mind and saw it through his eyes. And I just kind of did what he asked me to do. And all of a sudden, "Where did he get this anger that he has, this mistrust of the world? And he used force to get his way." And I said, "Well, from his dad." His stance was from being moved around when he was a kid, and never having a home. And I started rehearsing his story of where all this anger came from and then. Where did he get it? From, his dad. So I rehearsed a story about his dad which I don't remember what it was. I don't remember his story. And then I went back to his dad's dad, my great-grandfather. I told a story about how they were living on a farm. He was out in the farm yard and some of the horses stampede and he gets hurt and he's calling for help and nobody comes. And so he made a decision. That you can't trust life kind of a thing. Nobody's there to help you. You're on your own.

Then I went back in my mother's mind and did the same thing. And, my mother's story was that she had kinda gone without and they come from a poor family and had that experience. I skipped my mother's mother and went to my great grandmother after that. I rehearsed this whole story about how she came from a pretty wealthy family, sophisticated, and married beneath the family. And the man she married finally had no get-up and go and she was the driver of the family and she had resolved in her life just to accept the, you know, the bad decision she'd made and carried a lot of anger and resentment and frustration about her husband and the consequences of her life. I mean, just different stories around that. I don't remember them all. It's been a couple of years. I'd met her when I was about a 3 year old boy. I can kind of see pictures of her in my mind. I can kinda remember her house. And him also. And there're still things I didn't know, I'm just telling these stories. Some of it I just started

blubbering, just an incredible release of energy, just started crying, crying uncontrollably.

Then he asked me to...first of all, from my great grandfather on my dad's side he just asked me to relive the experience only when I call out, just picture his parents coming and saving him. You know, they actually came. You know? And I started crying then that they did care for me. That they did love me, kind of a thing. And on my great grandmother on my mother's side he asked me to just to acknowledge that she really did suffer. That she really did go without. She really did, basically, give her life away to a lifestyle of living in a poor situation and staying with the man she married even though she was unhappy for most of her life about it. And to look forward, ...have her look forward and see me. And see what the result of that sacrifice on her part was. You know the man that I'd become and the blessing that she'd created because of that. And I cried at that one.

But I had an interesting experience. Once I saw even beyond her like all these...my predecessors from generations back just like cheering for me. Like, "somebody had got it." Somebody had got it finally, you know? ...It was like somehow my life had bearing on whatever their existence is now. I was incredibly emotional about them looking down and seeing. It wasn't down. It was like across from me just all lined up, cheering and excited. Somebody had finally got it! Somebody broke the chain, basically.

Just to let you know one thing that I did is that after a period of time I kind of recounted this with my mother. I wanted to know if any of these events really had taken place. And I had about 8-10 specific things that I recounted, like being hit, information about my dad and my great grandmother and her marrying beneath her and all. I related to her all of those things to see if, am I making this up or what? And she validated about eight of ten things including that my dad had slugged her late in her pregnancy with me.

Janov’s Primal Therapy

Douglas practiced primal therapy as a way to access

the pre- and perinatal. Some of the excerpts from his protocol graphically demonstrate this psychotherapy. The tenets of primal therapy teach that if one stays "present" emotionally, the psychodynamic workings of the mind will move toward healing by allowing repressed energies and memories to surface (Janov, 1983). Douglas describes knowing when he was having a "feeling." According to him, staying with those feelings led to the ultimate resolution of his pre- and perinatal trauma. Here is a sampling of Douglas's work with primal therapy.

- Douglas

Yeah something about it seemed familiar. So a friend of mine was a therapist, a primal therapist. And so I talked him into coming over one day. So I put on a swim suit, got in the shower and turned on the water as hot as I could stand it. And sure enough, the feelings came up. And we had made a little nest on the bathroom floor of towels and blankets and stuff. And so as soon as the feelings came on I'd say, "The feeling's coming on." And he'd help me get out of the shower real quick, lay down on the floor, and go into the feeling. And I just went right into the feeling. And it was the feeling of being born and having my head crushed and having so much pressure on my entire body from my mother just clamping down that I would fight and fight, struggle and struggle, and try to push. And I would be in a rage trying to get out cause she wasn't helping me. And the intense pressure along with the intense rage I was having then I would black out. It would finally get too much for my nervous system and I would just black out. And so I went into those feelings there on the bathroom floor of just like raging and blacking out, and then raging and then blacking out and then crying, crying and then raging and then blacking out and then crying and just cycling through these feelings. And then finally the raging and the crying went away. And then I probably had to do that another...you know take a shower and let the black-outs start to come on, I had to lay down on the floor maybe another half a dozen times after that. And then it hasn't happened since. Now that was 15 years ago. No that was more like 20...25 years ago.

And so that night after the flight I awoke at like 2 or 3 in the morning from a deep sleep. I just went, "panicky inhale." I just woke up. Just like that. And it was like a nightmare except that there were no images. There were no symbols, just pure terror. After a couple of minutes I realized that I was in a feeling. I'd been in therapy enough in my life to recognize this was a feeling. So I ended up just laying down on the floor and breathing into what the feeling was. And immediately I just went into this shaking and crying and just terror. And immediately this image of my father popped into my mind, of him grabbing me and throwing me across the room and me going backwards. And I was flying through the air, thinking, "How am I going to land safely?" And so I felt that feeling and cried and shook and went through that. And then I just had this tremendous sense of relief after that.

And then when I went up flying the next day with my instructor I had him put me in unusual attitudes again. But the first time I did it without the hood. I said, "Okay, I need to work into this slowly. This terrifies me." And so he worked with me. He let me take it one step at a time. And then I would go home at night and feel my feelings about the terror and about being thrown by my father.

Obstetric Intervention

The following are excerpts from the protocols of Marisa, Douglas, and Caroline that pertain to obstetric intervention. Also included are portions of Caroline’s text about her experience of surgery without anesthesia. These phenomena are discussed below in the discussion section, and in the literature review (p. 68).

- Marisa

And so he did knock her out. I didn't get any help at all. And it was really,
really, really hard. ...Finally, it seemed like even though she was drugged, I was drugged, and it was hopeless, I was making progress.

The next thing I remember is feeling these cold metal instruments grab around my head and pull on me. And it was so infuriating to me. I really wanted to just rip the doctor's head off. I've never felt such rage in my life. When this came up in a birthwork session I felt like I could just rip the whole place down because I felt like my experience was taken away from me. And I had done all the work. And then I didn't even get to get born. This man just ripped off my triumph.

- Douglas

Part of my deep depression was involved with anesthesia. And how I realized that was tied in is that I was still going through a lot of depression a number of years ago. And I would get depressed and I would sort of fade out. Like I could be at a workshop for example and I couldn't stay awake. And I would just literally go unconscious. And I kept on going unconscious. And then actually William worked with me. And he recreated the pressure on my head that was similar to the pressure I felt at birth. And also the pressure of forceps especially over my right ear where the forceps were really cramping hard. And what it did is it triggered the memory of the forceps but also it triggered the memory of being anesthetized to the point where I left my body and numbed out. And lost connection with my resources to fight or flee. And with him applying a lot of pressure over my right temple and ear it triggered that desire to fight or flee...the intensity. And at that point I started connecting up my depression and sleepiness to being anesthetized and being chemically severed from my ability to fight the situation or flee from it due to going into dissociation and numbness. And that was a big piece 'cause that helped relieve another chunk of the depression once I got that piece.

I also retrieved a memory of being born and being held upside down and having that feeling of vertigo and just went, "Ahhhh! What's happening? What are you doing? Are you gonna drop me?" And so it was retrieving that memory of being held upside down at my birth where I was held upside down and spanked because I wasn't breathing. And so that was also entwined with that feeling of vertigo, being out of control, terrified.

- Caroline

The anger came from the fact that I was doing so well until my mother took this drug and when she took this drug so that she would not feel the labor I slowed down too. I was unable to move and this infuriated me. And so we went into that memory at least 10, 12 times. And again I felt a great deal of untwisting taking place in my body. A lot of freeing up.

...one day Dr. C. and I went into the fact that I'd received transfusions immediately upon birth. And that was because I was an unexpected RH baby and the first transfusion was the wrong blood. They brought up the wrong blood from the laboratory. And they'd even started giving it to me. My body went into complete shock. And on the couch with Dr. C., I think for about 30 minutes, I was convulsing as I remembered this memory. And almost immediately they got the right blood. They realized something was wrong. When Dr. C. and I brought up this memory my fear of food went away and I went back to eating meat. I eat anything I want now. I thought I went into not eating meat because of noble longings. The purer you are the more spiritual you are type of thing. But it actually boiled down to wanting to purify my body out of fear of toxic poisoning and dying from the toxins in my food. And it stemmed from the birth.

And then I had a session where... it's really odd the way they gave me transfusions. They would cut about an inch long. I have scars all over my body. Three on each foot and then I had a session where...it's really odd the way they gave me transfusions. They would cut about an inch long. I have scars all over my body. Three on each foot and one on each hand and several on my head from the transfusions they were giving me. And they would hold the...they would cut me without anesthetic. And the cut was about an inch long, so that if it was on my hand it would cover my whole hand. And then they would put a wooden splint there. And they would be giving me blood through...I don't know...I imagine the standard tube-type of blood. But when Dr. C. put me under for that I felt the pain of the knife. I could actually feel the pain as though I was there having surgery without the anesthetic. And

what I did to...because this was done so many times on my body ...was to learn at that point in my life to leave my body. It was very easy for me to leave my body from that point on. Because I was being cut quite a bit.

Fetal and Transcendent Consciousness

At least two types of consciousness became apparent throughout the study, that of fetal and transcendent. This can be seen in the testimony of the co-researchers while describing their plight. Fetal consciousness is tied to the fetal body, whereas, transcendent is a mature consciousness thought to be located outside of the baby and the mother. It is thought to attach to the fetus sometime during the third trimester, or within two days of birth (Wade, 1996). Awareness of parental experience on the part of the participant is an example of transcendent consciousness. These excerpts seem to hold a combination of both types of consciousness.

- Marisa

And I never lost the sense of it being polluted and of my life being in danger. I was like...felt really assaulted. My mother thought she might be pregnant. She didn't want to be pregnant.

So then I continued to hang out in there and grow. And I just felt really awful that my mother would prefer to die rather than have me.

- Douglas

I just went into this shaking and crying and just terror. And immediately this image of my father popped into my mind, of him grabbing me and throwing me across the room and me going backwards. And I was flying through the air, thinking, "How am I going to land safely?" And so I felt that feeling and cried and shook and went through that.

- Caroline

And there was a pressure that was being applied there.

There was no concern for my welfare. And it was probably what you would call "rough sex" And there was pressure applied on me. And I felt cut off from my oxygen and I was panicked inside the womb.

- Rachel

I was still trapped in the middle of this birth regression thing and trapped, you know stuck...stuck in this room situation and still felt like I was trapped in a sewer. And it was still hard to breathe. But it wasn't the same sort of choking...where I felt like I was going to die. It was very different. I could breathe. I was still stuck but I could breathe. And I knew that the whole asthma thing was gone.

- Jesse

And the second he said "The 3rd trimester of pregnancy?" I had pain on my whole right side. My whole right side went to pain. ...So I said, "Well my dad has just hit my mother in the stomach."

A Comparison of the Findings With the Literature Review

This comparison revealed a confirmation of the reviewed literature in support of fetal and neonatal consciousness and memory. Further, if the data are to be believed, the concept of repression is strongly supported. It is at odds with those who profess it to be impossible (Kihlstrom, 1997; Loftus, 1994; Pope & Hudson, 1995; Yapko, 1994).

Because of established requisites phenomena such as healing through pre- and perinatal recall cannot fit within the traditional scientific paradigm. These principles, including the “scientific method,” require that phenomena (a) be replicable under controlled circumstances, (b) be quantifiable, and (c) be experienced by one of the five basic human senses. It is patently accepted that memory and consciousness are an outcome of the maturation of the CNS. All of this is in contradiction to the current study. The interviewees could relate their pre- and perinatal recollection and the ostensible symptom alleviation for purposes of this study but controlled replication

is not as yet possible. Rather, I submit that this study offers significant support in favor of a holonomic paradigm (Bohm, 1980, 1986).

If one accepts the results of the current study as veracious, then concepts such as incomplete myelination, infantile amnesia, and an immature CNS which prevent pre- and perinatal memory are seriously challenged. Literature noted in the current study stating that myelination is an unnecessary component to pre- and perinatal memory may be validated instead (Chamberlain, 1988; Grof, 1985; Pearce, 1992; Verny & Kelly, 1981; and Wade, 1996). Further, if it is true that what the interviewees claimed to have experienced was the memory of their pre- and perinatal life, memory theory other than that attributed to the CNS, that is, Bohm's (1980, 1986a, 1986b) theory of holonomic memory, Sheldrake's (1995) morphic resonance, and conceptions of cellular and somatic memory (Buchheimer, 1987; Farrant, 1987; Hubbard, 1950; Pert, 1987a, 1987b; Pribram, 1971; van der Kolk 1989, 1994; van der Kolk & van der Hart, 1991) are also supported by the evidence presented herein.

The neuropeptide research of Pert, Ruff, Weber, and Herkenham (1985), van der Kolk's work with PTSD and the limbic system (1994, 1996), and Prescott's (1995) studies of the trauma of insufficient maternal-infant bonding all receive support from the results of this study. The co-researchers demonstrated that very early trauma may somehow be stored in the bodymind, expressed in psychosomatic conditions through adulthood, and then accessed for purposes of resolution. Further, Wade's (1996) premise that neonates utilize co-existing and overlapping types of consciousness can be viewed throughout the testimony of the participants as they (a) demonstrate fetal consciousness by having awareness of their bodily experience, and (b) exhibit transcendent consciousness with a mature understanding of their situation, and the attitudes and feelings of those around them. Demonstration of this mature consciousness is reflected by the individual theme, The Perception of Mother's or Others' Reality.

Some of the healing reported by the co-researchers in the current study such as the cure of headaches and the alleviation of depression and suicidality were also reported by the participants in Ruch's (1996)

investigation,
Interviewees saw the working through of birth and related phenomena as an important element in the self-healing process. On many occasions emotional and somatic problems such as headaches, depression and even suicidal ideation

improved or disappeared altogether. (abstract, p. iii)

Grof (1985) reports, “Difficult emotional and psychosomatic symptoms that could not be resolved on the biographical or perinatal level disappear or are considerably mitigated when the subject confronts various embryonic traumas” (p. 354). Janov (1983) lists many physical and psychological afflictions he believes to stem from birth such as, asthma, angina, migraines, pnigerophobia (fear of being smothered), sexual dysfunction, upper respiratory disorders, and many others.

Avid complaints were voiced by co-researchers with regard to medical intervention. These involved, forceps deliveries, anesthesia during labor, surgery without anesthesia (transfusion), and inversion at birth. Feeling unwanted or rejected, and not being allowed to bond with their mothers were the most painful psychological factors reported. Ruch (1986) once again confirms the findings,
The most frequently mentioned disturbances were medical interventions, unforeseen complications and psychological difficulties. ...the more the mother-baby relationship is disturbed at birth, the greater the likelihood that this bond of reciprocal responsiveness is stretched to the breaking point. (abstract, p. iii)

The distress felt by a birthing perinate after technological intervention was reflected by Marisa (anesthesia, forceps), Douglas (anesthesia, forceps), and Caroline (anesthesia, transfusion, surgery without anesthesia). The possible long-term effects of such intervention were indicated by conditions such as migraine headaches, syncope, phobias, arthritis, and depression which lessened or disappeared upon the reliving of these events.

Utilizing "non-ordinary states of consciousness" in psychotherapy for more than 30 years, Stanislav Grof

has formed conclusions that are directly supported by the experiences of the participants in this study. The protocols of Marisa, Douglas, Rachel, Caroline, Amy, and Jesse reflect the healing of emotional and psychosomatic conditions after revisiting pre- and perinatal trauma. Grof (1973, 1985, 1988) frequently refers to the strong possibilities of symptom alleviation through the remembrance of trauma on all levels of the pre- and perinatal.

Many of the terms used by Grof (1985, p. 112-116) to describe the suffering felt by laboring prenates in the Basic Perinatal Matrices II and III are replete in the protocols of Rachel, Douglas, Karlton, and Caroline. References to feelings of being crushed, trapped, suffocated, panic stricken, and of dying can be found throughout. One remarkable difference between these protocols and Grof's BPM IV, however, is that none of his descriptions of the enormous relief felt by the newborn upon the resolution of labor and delivery are mentioned by the participants of the current study, with the exception of symbolic mention by Jesse. Jesse's protocol stays in BPM I except for his contact with the transpersonal as seen in his ancestral memories. There he feels the cheering of ancestors as he "finally got it." This imagery classic to the celebration of the moment of birth (BPM IV). Further still, mentions of relief or healing by the co-researchers can be seen in this light.

In reviewing Grof, Ruch (1986) notes most of the subjects in his study reporting at least some positive womb experiences as in Grof's BPM I (Grof, 1985, p. 102). As in the current study, Ruch does not record the positive experiences of BPM IV. Khamsi (1987) reports subjects feeling "ecstatic" or "that they weren't going to make it" depending upon whether they could breathe freely or felt suffocated (p. 50). The co-researchers of the current study mention only those negative feelings related to the inability to breathe. Khamsi's subjects also reported, "It was like sex in its all-encompassing, intensely physical, transcendental quality; and for many there was an aftermath of relief and release" (p. 49) as in Grof's reference to BPM IV. Participants in the current study made very little mention of positive feelings, and no reference to sexual experience.

While one could postulate that the remembrances of

the co-researchers were merely a matter of backwards projection, that is, memories, attitudes or suppositions formed in childhood or later, and then projected backwards onto their pre- and perinatal experience, the veridical recordings of the movements of birthing infants painstakingly recorded by Cheek (1974, 1975) give rise to considerable doubt of that idea when used in conjunction with Karlton's description of certain head pressures, movements, and bodily changes during the remembrance of his birth. The possibility of having been unduly influenced by what he had read notwithstanding, Karlton felt that his reenactment closely resembled the description of a birthing infant's movements taught by Emerson (1978, 1987, 1998). Further, Grof (1985) and Janov (1983) give descriptions of the rigors of the reenactment of birth that closely resemble the trauma described by Douglas, Karlton, Marisa, Caroline, and Rachel.

In his work with memories of conception and attempted abortion, Graham Farrant (1987) lent credence to the conception remembrance of Marisa and Rachel, and the attempted abortion memories mentioned by Amy. Also, Marisa's heartbreak over the loss of her twin in utero substantiates experience described by LaGoy (1993) and Noble (1993).

Caroline gave testimony to a phenomenon described by Chamberlain (1991/1994) by remembering having surgery with no anesthesia right after birth. Pearce (1992) and Marshall, Stratton, Moore, and Boxerman (1982) also discuss this period of medical history.

In a phenomenological master's thesis on prenatal and birth experience, Nichols (1996) concludes the following, all of which is true for at least some of the co-researchers in the current study and some is true for all:

- Uterine life and birth are experiences in which the baby is conscious and aware.
- There exists a consciousness of the self as connected to the Divine.
- Baby is conscious of mother's feelings about the pregnancy.
- Mother's feelings are transmitted to baby and become baby's feelings.
- Baby has feelings about being born.
- During labor baby feels crushed and afraid.

- Baby feels labor as a life and death struggle.
- If mother does not help babies may feel they must do all the work of being born.
- If baby is not bonded to the mother it may cause a life-long feeling that mother is not there for the child.
- Experiences in the womb and at birth begin life-long patterns of behavior and ways of viewing other people and the world. (p. 135)

Conclusions from Khamsi's (1987) doctoral study, phenomenologically examining birth feelings among participants in primal therapy, can be seen to match conclusions drawn from the current study. "Most subjects felt they were born with feelings, some sense of the self, and an ability to think" (p. 55).

Caroline's experience lends sway to the literature on hypnosis and the resolution of birth trauma in a way that can be independently verified by medical authority (Chamberlain 1983, 1986, 1988, 1990, 1992, 1993, 1994; and Cheek 1974, 1975, 1986, 1992).

Salk, Lipsitt, Sturner, Reilly, and Levat (1985) correlated the factor of respiratory distress for more than 1 hour at birth significantly with subsequently elevated suicide rates in adolescence, suggesting that events occurring during labor may remain indelibly imprinted on the mind. As such, Douglas' and Marisa's suicidal tendency after suffering asphyxia at birth could be linked with this finding.

The idea of fetal competence demonstrated by studies cited in the current work, such as Baker (1978); Birnholz, Stephens, and Faria, (1978); De Casper and Fifer (1980); Hepper (1988); Piontelli (1992); Sallenbach (1994) and Shetler (1989) can be identified in Marisa's interview when she determines to take less in order to save her twin, looks forward to being with her little brother, or determines to begin labor on her own. Douglas' and Amy's experience of remembering feeling their mothers' grief in utero is corroborated by Gabriel and Gabriel (1992). Gabriel describes his own birth regression and gaining the awareness of his mother having lost her lover and being in a state of grief during his gestation. This was later validated by an older sibling.

A Discussion of the Results

In the first chapter I expressed my hope of illuminating the experience of healing through the remembrance of the pre- and perinatal. Secondary objectives included examining the healing benefits of the experience, and raising awareness of the long- and short-term side effects of routine obstetric intervention. I believe the study was successful in its first two aims, at least. Illumination of the experience of healing through the pre- and perinatal can be viewed throughout this chapter, in the protocols, and the summaries. The structure of the experience is also described succinctly in the individual, general, and unique themes.

Because many consider pre- and perinatal remembrance to be confabulation or backwards projection, I focused this study on demonstrable healing. My aim was to bring the phenomenon further into the realm of the believable. The co-researchers, however, manifested their healing minimally in transcripts. They focused, as requested, on their experience, not their results. The only way to pursue my second objective of examining the healing benefits was to ask them directly. This was accomplished via the follow-up question, What about the experience of healing through the remembrance of the pre- and perinatal was healing for you?

Since qualifying for the study required an alleviated physical or psychospiritual condition brought about through pre- or perinatal recall, it is not surprising that the experience affected the participants in profoundly positive ways. Their rather impressive gains were noted from the outset of the study. Karlton's change in vision, Caroline's healing of arthritis, and Rachel's relief from asthma are some of these. Other benefits surfaced, however, that are considered by most of the interviewees to be more important than the known conditions. My interpretation of these expressions of healing include, self-empowerment, a feeling of more control over life, and freedom from anger and hatred. Further, all co-researchers expressed their healing in terms that indicate an overall enhancement of the quality of their lives. A summary of these results can be found under the heading, Results of the Follow-up Question.

An illumination of the long- and short-term effects of routine obstetric intervention was possible through the original interviews. The alleviation of depression on Douglas's part after reexperiences of anesthesia during labor provides some insight as to a possible long-term consequence. Marisa and Caroline related feeling that their mothers stopped helping with the labor after being anesthetized, that the labor was slower, and that they felt they had to do all the work. About this, Ruch (1986) writes, "...many reported difficulty breathing, felt immobilized or held back, and shared a sense of having to do all the work of delivery by themselves" (p. 190). Addictive drug use reported by Marisa may support the work of Jacobsen (1988) espousing the hypothesis that anesthesia during labor can lead to drug addiction in offspring. Douglas and Marisa complained of the pain that forceps gave them. Further, Marisa experienced the doctor's use of forceps as a "rip off" since she had struggled valiantly to be born and felt her journey was intercepted and the "triumph" of her birth preempted.

Caroline recalled surgery without benefit of anesthetic immediately after birth. Born with Rh negative blood, she required a transfusion and was cut several times without being anesthetized. While the transfusion could not be classified as a routine obstetric intervention, it does exemplify the decades during which medical science espoused the belief that babies could not feel pain (Chamberlain, 1991).

In reality, raising awareness of how obstetric intervention affects neonates is a goal that will most likely manifest in time, as will the awareness of fetal and neonatal consciousness. Hopefully, this study will play a part in that evolution. Three of the co-researchers recalled what they felt was their perinatal experience with technology, and the ways it hurt them. Pertinent studies were underscored in the literature review. However, as awareness of pre- and perinatal memory and its possible benefits appears to be limited at this point in time, the effects of this and other research like it remains to be seen. These results are exhibited under the sub-heading, Routine Obstetric Intervention, and are interwoven with other themes and excerpts

Two descriptive categories represent the structure of

the experience under investigation, in general. The themes, Intensely Felt, Mostly Negative, Emotional, Physical, and Feeling States, and Transpersonal Experience capture the essence or underpinnings of the phenomenon. Remembering the pre- and perinatal, then, at least for those who have been traumatized by it, could be called, “A Painful and Scary Transpersonal Experience.” Perhaps naively, I did not expect the data analysis to reveal such pain. Apparently, the experience of healing trauma severe enough to produce psychological and physical disorders, through pre- and perinatal remembrance, is a virtually joyless proposition.

From the grand total of 97 cluster headings, 62 or 64% of the them comprised the individual theme, Anguished Emotional, Physical, and Feeling States. This preponderance of negative experience left the other six themes to be composed of 35 or 36% of the headings. Dividing them equally, each remaining theme is then made up of only 5.8 or 6% of the headings. The theme representing intense discomfort is clearly overrepresented. Accordingly, negative expressions of Grof’s (1985) basic perinatal matrices (BPM), that is, BPM II, BPM III, and negative aspects of BPM I are seen liberally throughout the protocols. These are the BPMs considered to contain the most painful aspects of the perinatal.

By contrast, positive expressions of the perinatal according to Grof (1985), positive aspects of BPM I, and BPM IV, were limited to the symbolic, in that they were not identified by the co-researchers as a part of their birthing experience. Examples of this are: (a) BPM I: Marisa’s experience as “a soul prior to birth.” She felt, “safe and warm” and sure of her purpose in coming to earth. This can be seen as representative of a symbiotic union with mother in the first trimester; and (b) Jesse’s joyful experience of the acknowledgment by his ancestors can also be seen as a representation of the celebration of birth in BPM IV. Sparse references to relief and healing by co-researchers can be viewed as symbols representing BPM IV, as well.

Ruch (1986), in studying birth remembrance among adults with a much larger (27) and broader sample, that is, not focusing on adults who could demonstrate symptom resolution, reached conclusions similar to

mine. He reported very few positive findings. Regarding the tremendous pain reported by co-researchers, and resulting, unexpected symptom resolution, Ruch (1986) writes,

> ...for most interviewees birth experiences as recalled in regressive therapy were difficult or traumatic. ...tremendous psychological and physical agony and discomfort accompanied these phenomena. Characteristic statements portraying them were “I am alone,” “I cannot make it,” “I need help/support.”...On many occasions emotional and somatic problems such as headaches, depression and even suicidal ideation improved or disappeared altogether. (abstract)

An unexpected outcome of the current research was that all of the participants felt abused by their parents as children, most in multiple ways. Alcoholism, neglect, and domestic violence; sexual, physical, and emotional abuse became apparent through the protocols and demographics form. Further, six of the co-researchers remembered varying types of abuse or neglect in utero. Marisa, Caroline, and Douglas felt unloved and unwanted. They also complained, by virtue of having received anesthetic, of having to do the labor of birth on their own. Rachel remembered conception during “marital rape,” Amy suffered the profound rejection of abortion attempts and adoption; and Jesse was actually punched in the third trimester.

In relation to the reviewed literature, and as far as I have known or heard, this finding is unprecedented. Some speculations are made earlier in the chapter as to how and why this unanimous maltreatment might have occurred. Responses to the demographics form (Appendix F) and information from the protocols (Appendix I) provide insight into this finding. It is presented under the heading, Results of the Demographics Form and in Tables 7 and 8.

Implications of the Findings

I am satisfied that this phenomenological investigation has both confirmed past research and contributed to the field in new ways. Renditions of the data and testimony of the co-researchers point to the reality of pre- and perinatal memory and consciousness. Further, the benefits of accessing that memory, however anguishing the content, can manifest in profound healing.

Some assert that birth itself is traumatic (Grof, 1985; Janov, 1983). Studies have suggested a wide variance of perinatal experience from despondency to bliss (Grof, 1985; Janov, 1983; Khamsi, 1987, Ruch, 1986). The current research, on the other hand, found a propensity for negative and traumatic remembrance, with almost no positive content. The co-researchers reported feeling unwanted, unloved, unsupported, and abused in multiple ways, both in and out of utero.

It seems to me that many of the pre- and perinatal traumatic memories and subsequent child abuse recall of the participants may represent the consequences of a combination of unprepared, dysfunctional people creating unwanted children, and obstetric intervention without full knowledge of its consequences. Negative domestic conditions such as substance and sexual abuse, domestic violence, and unplanned pregnancy were in place at the time of conception through birth. This reflects the dysfunctionality of the parental figures. The resulting lack of involvement and enthusiasm on the mothers' part in the birth process, and the ignorance of the medical establishment regarding the impact of obstetric intervention may have led to excessive anesthetic usage, forceps deliveries, reduced maternal participation, prolonged labor, and the improbability of bonding. Severance of the maternal connection during labor and lack of bonding after birth are believed to be principal causes of long-term emotional "shutdown," and related psychological dysfunction (Emerson, 1998; Grof, 1985; Janov, 1983; Prescott, 1995; Ruch, 1986). Co-researchers remember feelings of being unwanted, unloved, and of having to conduct the labor of birth single-handedly. Their lamentations are mirrored by life-long emotional and physical devastation which may be the result of these avoidable traumata. Frequent references by co-researchers to feelings of grief, being unwanted, feeling alone, rage, terror, panic, etcetera, and the amelioration of their symptomatology appear to reflect a lack of parental presence and caring. These stories raise important issues in how parental education might be handled in the future.

The fact that the current investigation focused on life-changing, symptom alleviation as a result of the remembrance of pre- and perinatal experience, and it revealed unanimous

trauma, despair, physical injury, and child abuse or neglect, suggests that overt symptom resolution from pre- and perinatal recall may be the result of especially traumatic pre- and perinatal experience. This allegation and the results of other studies indicate that the roots of some diseases, both psychological and physical, may go beyond genetics, to the pre- and perinatal or transpersonal realms of consciousness (Grof, 1972, 1985; Janov, 1983; Ruch, 1986). Further, since the etiology of disease may reach into the pre- and perinatal realms, a greater focus must be made on how that aspect of life is handled by parents, physicians, and others in the medical field.

Limitations of the Study

The study consisted of a small group of people who attested to demonstrable symptom alleviation through pre- or perinatal recall. They were difficult to find. Many prospective participants responded to the published advertisements, and other referrals, but only seven could depict the amelioration of a physical or psychospiritual condition. Several of the applicants had fascinating experiences to share, which were difficult to turn down. An example of this was a lovely young woman who told a story of living in India in an ashram. She had studied for several months with a guru. Before her departure back to the USA, she felt that her teacher had clairvoyantly directed her into the reexperience of her birth.

She recalled physical agony with a high fever and the feeling of being trapped and of dying. Even though there had been no discussion with the guru, and she had no knowledge of the phenomenon of birth remembrance, she knew that she was remembering her birth. Another candidate related, that as a six-year-old child he remembered his traumatic premature birth in a series of dreams and nightmares. Since these and other applicants had no evidential healing experience, I could not include them in the investigation.

In another instance, I was referred to the parents of a young child with significant birth trauma. According to the therapist who had been working with them, there had been a complete amelioration of a

cancerous condition. Notwithstanding assurances of anonymity, doing the interview with or without the child's presence, offers to fly to the Midwest for interviews or conducting them by telephone, the boy's mother opted not to participate. Such were the travails of finding appropriate co-researchers. Providing I could have found more cases, limiting the study to physical, documentable conditions, such as Karlton's vision change, rather than including cases of psychological improvement, may have produced an even more compelling treatise. Unfortunately, it would have taken more time to find participants, and more money.

While Polkinghorne (1989) asserts that a small number of co-researchers of the same culture can provide sufficient data for the analysis of a phenomenon, I do not believe that an all white, college educated, middle-income group of adults such as this one is a realistic representation. I was disappointed in the homogeneity of the sample. However, the lack of participants of color and other age groups may suggest that the psychotherapy used to access pre- or perinatal memory is prohibitively expensive, educationally esoteric, and unavailable in general. This rationale is beside the underlying certainty that therapeutically accessing our unconscious is little-known and virtually taboo in this country.

The investigation focused on participants who could attest to the healing effects of pre- and perinatal remembrance. It did not invite disagreement. Another way to frame the population would have been to elicit protocol from anyone who had attempted to heal with this phenomenon, whether or not they had succeeded.

Problems occurred in procuring responses to the original questionnaire early in the data collection portion of the project. This group was not forthcoming with written accounts of their very personal experiences. Perhaps the intense and painful nature of the phenomenon of perinatal remembrance was to blame for this. The co-researchers were, however, very willing to talk to me, the many times I contacted them.

Also, as discussed earlier in this chapter, I believe I made an error in the exclusion of part of Jesse's data. While I do not think the omission caused a significant aberration in the resulting individual and general themes, the likelihood that a third unique

theme would have emerged is high, and that loss is disappointing. At least the error was recognized, taken seriously, and underscored in the text.

Lastly, I would be remiss in not mentioning that unknown influences could have played a part in the remembrances of the co-researchers. For example, overheard conversations of their births or gestation periods by parents or involved others could have been construed by them later as memory. Suggestions or cues by therapists could have prompted the imagination or the desire to please. For those working in groups, hearing tales of birth by others may have colored their remembering experiences. Memory has been shown repeatedly to be fallible, reconstructed, and sometimes completely false (Brandon et al., 1998).

Suggestions for Further Research

The study's examination of obstetric intervention and the illumination of the experience of receiving it, suggest that kinder, more thoughtful systems of birthing children are called for (Grof, 1985; Leboyer, 1976). Greater awareness of and research into the natural rhythms between mothers and babies could result in less traumatic birth, hopefully reducing long-term, pathological outcomes. Studies on the short- and long-term impact of medical intervention on mothers and babies is vital. Further, the education of expectant parents on the options available to them and the risks involved in obstetric interventions, such as ultrasound, anesthesia, vacuum extraction, or circumcision could lead to more informed decision making, and a less destructive impact on the fetus and neonate.

Last but not least are the profound possibilities for healing that this research presents. The possibility of finding cures or alleviating such life-destroying conditions as asthma, phobia, migraines, syncope, visual impairment, and depression is impressive if not daunting. If more research is conducted that can demonstrate the depth of healing available through accessing the unconscious mind, the taboo surrounding it could be mitigated as well.

REFERENCES

Adzema, M. (1985). A perspective on spirituality. Journal of Humanistic Psychology, 25, (3), 83-116.

Alkon, D. L. (1979). Voltage-dependent calcium and potassium ion conductances: A contingency mechanism for an associative learning model. Science, 205, 810-16.

Alpert, J. L. (1995). Professional practice, psychological science, and the delayed memory debate. In J. Alpert (Ed.), Sexual abuse recalled: Treating trauma in the era of the recovered memory debate (pp. 3-26). New Jersey: Jason Aronson, Inc.

Alpert, J. L. Brown, L. S., Ceci, S. J., Courtois, C. A., Loftus, E., & Ornstein, P. A. (1996). Final conclusions of the APA working group on the investigation of memories of childhood abuse. Washington, DC, American Psychological Association.

Anand, K. J. S., & Hickey, P. R. (1987). Pain and its effects in the human neonate and fetus. New England Journal of Medicine, 317, 1321-1329.

Anderson, R., Braud, W., & Valle, R. (1996). Disciplined inquiry for transpersonal studies: Old and new approaches to research. Paper presented at the 76th Annual Convention of the Western Psychological Association, San Jose, CA

Arms, S. (1975). Immaculate deception. Boston: Houghton Mifflin Co.

Arms, S. (1994). Immaculate deception II. Berkeley, CA: Celestial Arts Press.

Bache, C.M. (1998). Dark night, early dawn: Steps toward a deep ecology of mind. In press: State University of New York.

Baker, (1978). Technological intervention in obstetrics. Obstetrics and Gynecology, 51, (2), 241-244.

Barnett, E. A. (1980a). Hypnoanalysis and the negative birth experience. Medical Hypnoanalysis, 169-172.

Barnett, E. A. (1980b). The ideomotor questioning finger technique: Some problems in its performance and interpretation. Medical Hypnoanalysis. 169-172.

Barnett, E. A. (1987). The role of prenatal trauma in the development of the negative birth experience. Pre- and Perinatal Psychology Journal, 1, (3), 191-207.

Bass, E., & Davis L. (1988). The courage to heal. New York: Harper and Row.

Bennett, R.T., Gill, B., & Kogan, S.J. (1998). Epididymitis in children: The circumcision factor? Journal of Urology, 160, (5), 1842-4.

Bernhardt, P., & Levine, P. (1992). Somatic approaches to traumatic shock (or post traumatic stress): A review of the work of the Bodynamic Institute, Albany, CA (Monograph) The Bodynamic Institute, Albany, CA.

Bernhardt, P., & Marcher, L. (1992). Individuation, mutual connection and the body's resources: An interview with Lisbeth Marcher. Pre- and Perinatal Psychology Journal, 6, (4), 281-294.

Bigelow, J. (1995). The joy of uncircumcising. California: Hourglass Publishing Co.

Birnholz, J. Stephens, J. C., & Faria, M. (1978). Fetal movement patterns. American Journal of Roentgonology, 130, 537-540.

Blum, T. (1993). Prenatal perception, learning and bonding. Berlin: Leonardo Publishers.

Blum, T., Dittman, R., Schulz, J., & Walker, J. (1993). Prenatal interventions and human proto-development. In T. Blum (Ed.), Prenatal perception, learning and bonding (pp. 107-131). Berlin: Leonardo Publishers.

Blume, E. S. (1990). Secret survivors: Uncovering incest and its aftereffects in women. New York: Ballantine Books.

Bohm, D. (1980). Wholeness and the implicate order. London: Routledge & Kegan Paul.

Bohm, D. (1986a). Time, the implicate order, and pre-space. In D. Griffin (Ed.), Physics and the ultimate significance of time (pp. 177-208). Albany: State University of NY Press.

Bohm, D. (1986b). A new theory of the relationship of mind and matter. The Journal of the American Society for Psychical Research, 80, 2.

Bohus, B., Kovacs, G. L., & De Wied, D. (1978). Oxytocin, vasopressin and memory. Brain Research, 157, 414-417.

Bowers, K. S., & Farvolden, P. (1996). Revisiting a century-old Freudian slip - From suggestion disavowed to the truth repressed. Psychological Bulletin, 119, (3), 355-380.

Bowlby, J. (1961). Separation anxiety: A critical review of the literature. Journal of Child Psychology and Psychiatry, 35, 3-25.

Brackbill, Y. (1964). Research in infant behavior: A cross-indexed bibliography. Baltimore. MD: Williams and Wilkins.

Brackbill, Y. (1979). Obstetrical medication and infant behavior. In J. D. Osofsky (Ed.) Handbook of infant development (pp. 76-125). New York: Wiley-Interscience.

Brandon, S., Boakes, J., Glaser, D., & Green, R. (1998). Recovered memories of childhood sexual abuse: Implications for clinical practice. British Journal of Psychiatry, 172, 296-307.

Braud, W. (1992). Human interconnectedness: Research indications. Palo Alto: unpublished manuscript.

Buchheimer, A. (1983). Memory - preverbal and verbal. Paper presented at the meeting of the 1st International Congress of Pre- and Perinatal Psychology, Toronto, Ontario.

Buchheimer, A. (1986). Memory - preverbal and verbal. In T. Verny (Ed.), Pre-and perinatal psychology: An introduction. (pp. 52-6). New York: Human Sciences Press.

Buchheimer, A. (1987). Graham Farrant interviewed at Appel Farm, Sunday, August 31, 1986. Aesthema, 7, 40-45.

Campbell, B. A., & Spear, N. E. (1972). Ontogeny of memory. Psychological Review, 79, 215-31.

Campbell, B. A., Misanin, J. R., White, B. C., & Lytle, L. D. (1974). Indirect support for neural maturation as a determinant of forgetting. Journal of Comparative and Physiological Psychology, 87, 2, 193-202.

Castellino, R. (1995). How babies heal. Santa Barbara, CA. Unpublished manuscript.

Ceci, S. J., & Bruck, M. (1995). Jeopardy in the courtroom: A scientific analysis of children's testimony. Washington, DC: American Psychological Association.

Chamberlain, D. B. (1982). Symposium commentary on Lloyd deMause's Fetal origins of history, Journal of Psychohistory, 10, (2), 222-229.

Chamberlain, D. B. (1983). Consciousness at birth: A review of the empirical evidence. (Available from Chamberlain Communications, San Diego, CA)

Chamberlain, D. B. (1986). Reliability of birth memories: Evidence from mother and child pairs in hypnosis, Journal of the American Academy of Medical Hypnoanalysts, 1, (2), 89-98.

Chamberlain, D. B., (1987). The cognitive newborn: A scientific update. British-Journal of Psychotherapy, 4, (1): 30-71.

Chamberlain, D. B. (1988). Babies remember birth: And

other extraordinary scientific discoveries about the mind and personality of your newborn. Los Angeles: Jeremy P. Tarcher, Inc.

Chamberlain, D. B. (1990). The expanding boundaries of memory. Pre-and Perinatal Psychology Journal, 4, (2), 171-190.

Chamberlain, D. B. (1991). Babies don't feel pain: A century of denial in Western medicine. Paper presented to the 2nd International Symposium on Circumcision. San Francisco.

Chamberlain, D. B. (1992). Is there intelligence before birth? Pre-and Perinatal Psychology Journal, 6, (3), 217-238.

Chamberlain, D. B. (1993). Prenatal intelligence. In T. Blum (Ed.), Prenatal perception, learning and bonding (pp. 9-31). Berlin: Leonardo Publishers.

Chamberlain, D. B. (1994). The sentient prenate: What every parent should know. Pre- and Perinatal Psychology Journal, 9, (1), 9-34.

Chamberlain, D. B. (1995). What babies are teaching us about violence: presidential address. Pre- and Perinatal Psychology Journal, 10, (2), 57-74.

Cheek, D. B. (1974). Sequential head and shoulder movements appearing with age-regression in hypnosis to birth. American Journal of Clinical Hypnosis, 16, 261-66.

Cheek, D. B. (1975). Maladjustment patterns apparently related to imprinting at birth. American Journal of Clinical Hypnosis, 18, 75-82.

Cheek, D. B. (1986). Prenatal and perinatal imprints: Apparent prenatal consciousness as revealed by hypnosis. Pre- and Perinatal Psychology Journal, 7, (2), 125-138.

Cheek, D. B. (1992). Are telepathy, clairvoyance and "hearing" possible in utero?: Suggestive evidence as revealed during hypnotic age-regression studies in prenatal memory. Pre-and Perinatal Psychology Journal, 7, (2), 125-138.

Clements, M. (1977). Observations on certain aspects of neonatal behavior in response to auditory stimuli. Paper presented at the Fifth International Congress of Psychosomatic Obstetrics and Gynecology, Rome.

Colaizzi, P. (1973). Reflection and research in psychology: A phenomenological study of learning. Dubuque, IA: Kendall-Hunt.

Connolly, J. A., & Cullen, J. H. (1983). Frontiers of infant psychiatry. USA: Basic Books, Inc.

Cook, L. N., Shott, R. J., & Andrews, B. F. (1974). Diagnostic amniocentesis: A review and report of a case with pneumothorax. Pediatrics, 53, 421.

Cortright, B. (1997). Psychotherapy and spirit: Theory and practice in transpersonal psychotherapy. Albany, NY: State University of New York Press.

Cowles, R. S. (1998). The Magic of hypnosis: Is it child's play? Journal of Psychology, 132, (4), 357-366.

Dabney, M. (1994). Many memories retrieved with hypnosis are accurate. American Journal of Clinical Hypnosis, 36, (3), 174-176.

Dahl, A.A., & Waal, H. (1983). An outcome study of primal therapy. Journal of Psychotherapy and Psychosomatics, 39, (3), 154-64.

Davies, M. G., & Frawley, J. M. (1994). Treating the adult survivors of childhood sexual abuse. New York: Basic Books.

DeCasper, A., & Fifer, W. (1980). Of human bonding: Newborns prefer their mothers' voices. Science, 208, 1174-76.

DeCasper, A., & Spence, M. (1982). Prenatal maternal speech influences human newborns' perception of speech sounds. Infant Behavior and Development, 9, 133-150.

DeCasper, A., & Prescott, P. (1984). Human newborns' perception of male voices: preference, discrimination, and reinforcing value. Developmental Psychobiology,17, 481-491.

deMause, L. (1981). The fetal origins of history. Journal of Psychohistory, 9, (1), 1-89.

Descartes, R, (1952). Meditations. In The Great Books of the Western World: Vol. 31. (p. 98). University of Chicago.

Devitt, M. (1995). The effects of time and misinformation on memory for complete events. Unpublished doctoral dissertation, University of North Dakota, Grand Forks.

Diamond, J. (1992). Our phantom children. Journal of Natural History, May, 18-23.

Dobbs, D. & Wilson, W.P. (1960). Observations on the persistence of traumatic war neurosis. Journal of Mental and Nervous Disorders, 21, 40-46.

Doblin, R. (1991). Pahnke's "Good Friday experiment." Journal of Transpersonal Psychology, 23, (1), 1-28.

Dywan, J. (1988). The imagery factor in hypnotic hypermnesia. International Journal of Clinical & Experimental Hypnosis, 36, 312-326.

Dywan, J., & Bowers, K. (1983). The use of hypnosis to enhance recall, Science, 222, 184-85.

Eisenberg, A. R. (1985). Learning to describe past experiences in conversation. Discourse Processes, 8, 177-204.

Emerson, W. R. (1978). Birth and life: The hazy mirrors. European Journal of Humanistic Psychology, 6, 17-23.

Emerson, W. R. (1987). Primal therapy with infants. Aesthema, 7, 61-67.

Emerson, W. R. (1998). Birth trauma: The psychological effects of obstetrical interventions. Journal of Prenatal and Perinatal Psychology and Health, 13, (1), 11-44.

Emerson, W. R., & Schorr-Kon, S. (1994). Somatotropic therapy. In D. Jones (Ed.), Innovative therapies (pp. 28-48). Bristol, PA.: Open University Press.

English, J. (1985). Different doorway: Adventure of a cesarean born. California: Earth Heart.

English, J. (1993). Being born cesarean: Physical, psychosocial, and metaphysical aspects. Pre- and Perinatal Psychology Journal, 7, (3), 215-230.

Eslinger, M. R. (1998). Hypnosis principles and application: An adjunct to health care. Seminars in Perioperative Nursing, 7, (1), 39-45.

Ewin, D. M. (1994). Many memories retrieved with hypnosis are accurate. American Journal of Clinical Hypnosis, 36, (3), 174-176.

Farrant, G. (1983). Cellular consciousness, a video. Boston: NOVA/WBGH Transcripts, 125 Western Ave. Boston, MA 02134.

Farrant, G. (1987). Cellular consciousness. Aesthema, 7, 28-39.

Fedor-Freybergh, P. G., & Vogel, M. L.V. (Eds.) (1988). Prenatal and perinatal psychology and medicine: Encounter with the unborn. Lancashire, UK.: Parthenon Publishing.

Feher, L. (1980). The psychology of birth: Roots of human personality. New York: The Continuum Publishing Corporation.

Feher, L. (1989). Perinatal issues. New York: The Association for Birth Psychology.

Ferguson, M. (1982). Karl Pribram's changing reality. In K. Wilber (Ed.), The holographic paradigm and other paradoxes (pp. 15-27). Boulder and London: Shambhala.

Ferlemann, M. (1972). LSD: Miracle or menace? Menninger Perspective 3, (2), 11-15.

Findeisen, B. R. (1986). Journey to be born: An introduction to pre-and perinatal psychology (video). (Available at The STAR Foundation. Geyserville, CA).

Findeisen, B. R. (1993). Pre- and perinatal losses. Pre- and Perinatal Psychology Journal, 8, (1), 65-77.

Fodor, N. (1949). The search for the beloved: A clinical investigation of the trauma of birth and prenatal conditioning. New Hyde Park, NY: University Books.

Frankel, F. H. (1990). Hypnotizability and dissociation. American Journal of Psychiatry, 147, (7), 823-829.

Freud, S. (1893/1974). The psychotherapy of hysteria. London: Hogarth Press and Penguin Books.

Freud, S. (1896/1974). The etiology of hysteria. London: Hogarth Press and Penguin Books.

Freud, S. (1900/1965). The interpretation of dreams. New York: Avon Books.

Freud, S. (1905/1959). Three essays on the theory of sexuality. In J. Strachey (Ed. and Trans.), The standard edition of the complete psychological works of Sigmund Freud, 7, (pp. 125-243. London: Hogarth Press.

Freud, S. (1919/1954). Introduction to psychoanalysis and the war neuroses. In J. Strachey (Ed. and Trans.), The standard edition of the complete psychological works of Sigmund Freud, 17, (pp. 207-210). London: Hogarth Press.

Freud, S. (1926a/1936). The problem of anxiety. New York: The Psychoanalytic Quarterly Press and W. W. Norton & Company.

Freud, S. (1926b/1936). Inhibitions, symptoms and anxiety. New York: W. W. Norton & Company, Inc.

Friedman, E., & Neff, R. (1987). Labor and delivery: Impact on offspring. Massachusetts: P. S. G. Publishing.

Fries, M. (1937). Longitudinal study: Prenatal period to parenthood. Journal of the American Psychoanalytic Association, 25, (1), 115-132.

Gabriel, M. (1992). Voices from the womb. Lower Lake, CA: Aslan Publishing.

Gallagher, S. (1996). The moral significance of primitive self-consciousness: The response to Bermudez. Ethics, 107, 129-140.

Galluscio, E. H. (1990). Biological psychology. New York: Macmillan.

Gay, P. (1988). Freud: A life for our times. Markham, Ontario: Penguin Books, Canada.

Giorgi, A. (1975). An application of phenomenological method in psychology. In A. Giorgi, C. Fisher, & Murray (Eds.), Duquesne studies in phenomenological psychology (pp. 82-103). Pittsburgh: Duquesne University Press.

Giorgi, A. (1985). Phenomenology and psychological research. Pittsburgh: Duquesne University Press.

Giorgi, A., Fischer, W. F., & von Eckartsberg, R. (1971). Duquesne studies in phenomenological psychology: Vol. I. Pittsburgh: Duquesne University Press.

Givens, A. (1987). The Alice Givens approach to prenatal and birth therapy. Pre- and Perinatal Psychology Journal, 1, (3), 223-229.

Gleaves, D. H. (1996). The evidence for “repression”: An examination of Holmes (1990) and the implications

for the recovered memory controversy. Journal of Child Sexual Abuse, 5, (1), 1-19.

Gregory, R. L. (Ed.). (1987). The Oxford companion to the mind. New York: Oxford University Press.

Grimwade, J. C., Walker, D., & Wood, C. (1971). Human fetal heart range change and movement in response to sound and vibration. American Journal of Obstetrics and Gynecology, 109, 86-91.

Grof, S. (1972). Varieties of transpersonal psychology: Observations from LSD psychotherapy. Journal of Transpersonal Psychology, 4, (1), 45-80.

Grof, S. (1973). Theoretical and empirical basis of transpersonal psychology and psychotherapy: Observations from LSD research. The Journal of Transpersonal Psychology, 1, 15-52.

Grof, S. (1975). Realms of the human unconscious. New York: Viking Press.

Grof, S. (1979). LSD psychotherapy. Pomona, CA: Hunter House.

Grof, S. (1985). Beyond the brain: Birth, death and transcendence in psychotherapy. Albany: State University of New York Press.

Grof, S. (1988). The adventure of self-discovery. Albany, New York: State University of New York Press.

Grof, S., & Bennett H. Z. (1990). The holotropic mind: The three levels of human consciousness and how they shape our lives. San Francisco: Harper Publishing.

Grof, S., & Grof, C. (1980). Beyond death. London: Thames & Hudson.

Hahnemann, S. (1810/1976). Organon of medicine. Los Angeles: J. P. Tarcher, Inc.

Hammond, DC (1997). Advantages and safeguards in using the ideomotor signaling: A commentary of Walsh and clinical practice. American Journal of Clinical Hypnosis, 40, (1), 360-67.

Haverkamp, A. D., Thompson, H. E., McFee, J. G., & Getrulo, C. (1976). The evaluation of continuous fetal heart rate monitoring in high-risk pregnancies. American Journal of Obstetrics and Gynecology, 125, 310-317.

Hendricks, G., & Hendricks, K. (1987). Techniques for dealing with prenatal and perinatal issues in therapy: A bodymind perspective. Pre- and Perinatal Psychology Journal, 1, (3), 230-238.

Hepper, P. G. (1988). Fetal “soap” addiction. The Lancet, 1347-1348.

Hill, L. M., Platt, L. D., & Manning, F. A. (1979).

Immediate effect of amniocentesis on fetal breathing and gross body movement. American Journal of Obstetrics & Gynecology, 135, 689-690.

Holmes, D. S. (1974). Investigations of repression: Differential recall of material experimentally or naturally associated with ego threat. Psychological Bulletin, 81, 632-653.

Holmes, D. S. (1990). The evidence for repression: An examination of sixty years of research. In J. L. Singer (Ed.), Repression and dissociation: Implications for personality theory, psychopathology, and health (pp. 85-102). Chicago: University of Chicago Press.

Holmes, S.W., Morris, R., Clance, P.R., & Putney, R.T. (1996). Holotropic breathwork: An experiential approach to psychotherapy. Psychotherapy, 33, (1), 114-20.

Howe, M. L., & Courage, M. L., (1993). On resolving the enigma of infantile amnesia. Psychological Bulletin, 113, 305-326.

Hubbard, L. R. (1950). Dianetics: The modern science of mental health. Los Angeles: Scientology Publications.

Hull, W. F. (1986). Psychological treatment of birth trauma with age regression and its relationship to chemical dependency. Pre- and Perinatal Psychology Journal, 1, (2), 111-134.

Husserl, E. (1962). Ideas: General introduction to pure phenomenology. New York: Collier.

Hycner, R. (1982). Some guidelines for the phenomenological analysis of interview data. Unpublished material.

Iannirubertо, A., & Tajani, E. (1981). Ultrasonographic study of fetal movements. Seminars in Perinatology, 5, 175-181.

Immerman, R.S., & Mackey, W.C. (1997). A biocultural analysis of circumcision. Journal of Social-Biology, 44, (3-4), 265-275.

Irving, M. (1995). Critical literature review and bibliography of pre- and perinatal psychology and art therapy: With an addendum on natalism and natalistic art in therapy. Toronto: Carriage House Studios.

Jacobs, W. J., & Nadel, L. (1985). Stress-induced recovery of fears and phobias. Psychological Review, 98, 512-531.

Jacobsen, B. (1988). Perinatal origin of eventual self-destructive behavior. Pre- and Perinatal Psychology Journal, 2, (4), 227-241.

Jacobsen, B., Nyberg, K., Gronbladh, L., Eklund, G.,

Bygdeman, M. & Rydberg, U. (1990). Opiate addiction in adult offspring through possible imprinting after obstetric treatment. British Medical Journal, 301, 1067-1070.

James, W. (1890). Principles of psychology. New York: Holt.

Janet, P. (1889). L'Automatisme Psychologique. Paris: Alcan.

Janov, A. (1970). The primal scream. New York: G. P. Putnam's Sons.

Janov, A. (1976). Pain in sleep: An analysis of the mechanism of repression. Journal of Primal Therapy, 3, (2), 121-158.

Janov, A. (1983). Imprints: The lifelong effects of the birth experience. New York: Anchor Press/Doubleday.

Janov, A. (1991). The new primal scream. New York: Anchor Press/ Doubleday.

Jones, D. (1994). Innovative therapy: A handbook. Philadelphia: Open University Press.

Kafkalides, A. (1980/1995). The knowledge of the womb. Corfu, Greece: Olkos Publishing House.

Kant, I. (1781/1996). Critique of pure reason. Indianapolis: Hackett.

Karon, B. P., & Widener, A. J. (1998). Repressed memories: The real story. Journal of Professional Psychology: Research and Practice, 29, (5), 482-487.

Kegan R. (1982). The evolving self-problem and process in human development. Cambridge: Harvard University Press.

Kelly, C. (1972). Post-primal and genital character. Journal of Humanistic Psychology, 12, (2), 61-73.

Khamsi, S. K. (1987). Birth revisited. Aesthema 7, 13-27.

Kihlstrom, J. F. (1997). Hypnosis, memory and amnesia. Philosophical Transactions of the Royal Society of London, 29, 1727-32.

Kihlstrom, J., & Evans, F. (1979). Memory retrieval processes during post-hypnotic amnesia. In J. Kihlstrom, & F. Evans (Eds.), Functional disorders of memory (pp. 179-218 (Hillsdale)., NJ: Erlbaum.

Kihlstrom, J., & Harackiewicz, J. (1982). The earliest recollection: A new survey. Journal of Personality, 50, 134-148.

Klaus, M. and Klaus, P. (1985). The amazing newborn. Reading, MA: Addison Wesley.

Kolb, L.C. & Multipassi, L.R. (1982). The conditioned emotional response: A subclass of chronic and delayed post traumatic stress disorder. Psychiatric Annals, 12, 979-987.

Kruger, D. (1979). An introduction to phenomenological psychology. Pittsburgh: Duquesne University Press.

Kvale, S. (1984). The qualitative research interview. Journal of Phenomenological Psychology, 14, (2), 171-196.

LaGoy, L. (1993a). The loss of a twin in utero's affect on pre-natal and post-natal bonding. International Journal of Prenatal and Perinatal Psychology and Medicine, 5, (4), 439-446.

LaGoy, L. (1993b). The loss of a twin in utero and the effects on the remaining twin. Unpublished manuscript.

Laibow, R. E. (1988). Birth recall: A clinical report. Pre- and Peri-natal Psychology Journal, 1, (1), 78-81.

Lamb, M. P. (1975). Gangrene of a fetal limb due to amniocentesis. Journal of Obstetrics and Gynecology, 82, 829-830.

Larimore, T., & Farrant, G. (1997). Six universal movements in expressed in cellular consciousness and their meanings. Primal Renaissance: The Journal of Primal Psychology, 1, (1), 17-24.

Lashley, K. S. (1929). Brain mechanisms and intelligence. Chicago: University of Chicago Press.

Lashley, K. S. (1960). The neuropsychology of Lashley. New York: McGraw Hill.

Leboyer, F. (1976). Birth without violence. New York: Alfred A. Knopf.

LeCron, L. M. (1963). The uncovering of early memories by ideomotor responses to questioning. International Journal of Clinical and Experimental Hypnosis, 11, (3), 137-142.

Legerstee, M. (1997). Contingency effects of people and objects on subsequent cognitive functioning in three-month-old infants. Social Development, 6, 307-21.

Lindsay, D. S., & Read, J. D. (1994). Psychotherapy and memories of childhood sexual abuse: A cognitive perspective. Journal of Applied Cognitive Psychology, 8, 281-338.

Lindsay, D. S. (1997). Increasing sensitivity. In J. D. Read, & D.S. Lindsay (Eds.), Recollections of trauma: Scientific evidence and clinical practice (pp. 1-24). New York and London: Plenum Press.

Lingis, A. (1986). Phenomenological explanation. Drodecht: Nijoff.

Locke, J. (1813). An essay concerning human understanding. Boston: Cummings & Hilliard and J. T. Buckingham.

Loevinger, J. (1976). Ego development: Conceptions and theories. San Francisco: Jossey-Bass.

Loftus, E. F. (1992). When a lie becomes memory's truth: Memory distortion after exposure to misinformation. Current Directions in Psychological Science, 1, 121-23.

Loftus, E. F. (1993). The reality of repressed memories. American Psychologist 48, 518-535.

Loftus, E. F. (1997). Memories for a past that never was. Current Directions in Psychological Science, 6, (3), 60-65.

Loftus, E. F. (1998). Manufacturing memory. American Journal of Forensic Psychology, 16, (2), 63-75.

Loftus, E. F., & Ketcham, K. (1991). Witness for the defense: The accused, the eyewitness, and the expert who puts memory on trial. New York: St. Martin's Press.

Loftus, E. F., & Ketcham, K. (1994). The myth of repressed memory: False memories and allegations of sexual abuse. New York: St. Martin's Press.

Loftus, E. F., Garry, M., Brown, S., & Rader, M. (1994). Near-natal memories, past-life memories, and other memory myths. American Journal of Clinical Hypnosis, 36, (3), 176-179.

Loftus, E. F., Garry, M., & Feldman, J. (1994). Forgetting sexual trauma: What does it mean when 38% forget? Journal of Consulting and Clinical Psychology, 62, 1177-81.

Loftus E. F., & Pickrell, J. E. (1995). The formation of false memories. Psychiatric Annals, 25, 720-25.

Lorenz, K. (1935). Imprinting. Journal of Ornithology, (83), 137.

Lowe, S.W., Purist, R.H. Smart, P.T. & Dooley, R.L. (1998). Routine use of ultrasound during pregnancy. Nurse Practitioner, 10, (60), 63-6, 71.

Lucas, W. (1993). Regression therapy: A handbook for professionals, vols. I & II. Crest Park, CA: Deep Forest Press.

Mahony, B.S. (1997). Ultrasound of the cervix during pregnancy. Journal of Abdominal Imaging, 22, (6), 569-78.

Manning, F. A., Platt, L. D., & Lemay, M. (1977). Effect of amniocentesis on fetal breathing movements. British Medical Journal, 2, 1582-1583.

Marcher, L., Ollars, L., & Bernhardt, P. (1990). The bodynamic imprint method of resolving birth trauma. Albany, CA: Monograph from the Bodynamic Institute.

Marshall, R. E., Stratton, W. C., Moore, & J. Boxerman, S. B. (1980). Circumcision I: Effects upon newborn behavior. Infant Behavioral Development, 3, 1-14.

Marshall, R. E., Porter, A. G. R., Moore J., Anderson, B., & Boxerman, S.B. (1982). Circumcision II: Effects upon mother-infant interaction. Early Human Development, 7, 367-374.

Maziade, M., Boudreault, M., Cote, R., & Thivierge, J. (1986). Influence of gentle birth delivery procedures and other perinatal circumstances on infant temperament: Developmental and social implications. The Journal of Pediatrics, 108, (1), 134-136.

McConkey, K. M., & Sheehan, P. W. (1995). Hypnosis, memory and behaviour in criminal investigation. New York: Guilford Press.

McConnell, J. V. (1962). Memory transfer through cannibalism in planarians. Journal of Neuropsychiatry, 3(Supppl. 1), 42-48.

Merleau-Ponty, M. (1962). Phenomenology of perception. London: Routledge & Kagan Paul.

Merskey, H. (1996). Ethical issues in the search for repressed memories. American Journal of Psychotherapy, 50, (3), 323-335.

Meyer, D. R. (1972). Access to engrams. American Psychologist, 27, 124-133.

Misiak, H., & Sexton, V. (1973). Phenomenological, existential and humanistic psychologies. New York: Grune & Stratton.

Mitford, J. (1963). The American way of death. New York: Simon and Schuster.

Mitford, J. (1992). The American way of birth. New York: Penguin Books.

Montagu, A. (1964). Life before birth. New York: Signet Classics.

Moss, R. C. S. (1986). Frank Lake's maternal-fetal distress syndrome: Clinical and theoretical considerations, Part I. In T. Verny (Ed.), Pre- and perinatal psychology: An introduction (pp. 201-208). New York: Human Sciences Press.

Moss, R. C. S. (1986). Frank Lake's maternal-fetal distress syndrome and primal integration workshop, Part II. Pre-and Perinatal Psychology Journal, 1, (1), 52-68.

Mott, F. (1960). Mythology of the prenatal life. London: Integration Publishing.

Mott, F. (1964). The universal design of creation. Edenbridge: Mark Beech.

Murphy, G. E. & Wetzel, R. D. (1980). Suicide risk by birth cohort in the United States, 1949-1974. Archives of General Psychiatry, 37, 519-23.

Mutter, C. B. (1990). Hypnosis with defendents: Does it really work? American Journal of Clinical Hypnosis, 32, (4), 257-62.

Neldam, S., & Pedersen, J. F. (1980). Fetal heart rate response to amnio- centesis. Journal of Perinatal Medicine, 8, (20), 209-212.

Newnham, J. P., Evans, S., Michael, C., Stanley, F., & Landau, L. (1993). Effects of frequent ultrasound during pregnancy: a randomized controlled study. The Lancet, 342, 887-891.

Nichols, C. (1996). Meeting the unborn: A phenomenological inquiry into prenatal and birth experience. Unpublished master's thesis, College of Notre Dame, Belmont, CA.

Noble, E. (1993). Primal connections: How our experiences from conception to birth influence our emotions, behaviour, and health. New York: Simon and Schuster.

Ofshe, R. J., & Singer, M. T. (1994). Recovered-memory therapy and robust repression: Influence and pseudomemories. International Journal of Clinical and Experimental Hypnosis, 42, (4), 391-410.

Ofshe, R. J., & Watters, E. (1993). Making monsters. Society, 30, 4-16.

Ofshe, R. J., & Watters. E. (1994). Making monsters: False memories, psychotherapy, and sexual hysteria. New York: Scribner.

Olio, K. A., & Cornell, W. F. (1994). Making meaning not monsters: Reflections on the delayed memory controversy. Journal of Child Sexual Abuse, 3, (3), 77-94.

Orne, E. C., Whitehouse, W. G., Dinges, D. F., Orne, M. T. (1996). Memory liabilities associated with hypnosis: Does low hypnotizability confer immunity? International Journal of Clinical & Experimental Hypnosis, 44, 354-67.

Pahnke, W. (1963). Drugs and mysticism: An analysis of the relationship between psychedelic drugs and the mystical consciousness. Unpublished dissertation. Harvard University, Boston, Mass.

Pearce, J. C. (1992). Evolution's end. San Francisco: Harper.

Pendergrast, M. (1997). Response to Karon & Widener (1997). Professional Psychology: Research and Practice, 29, (5), 479-481.

Penfield, W. (1959). The excitable cortex in conscious man. Springfield, IL.: Charles C. Thomas.

Penfield, W. (1975). The mystery of the mind. Princeton and London: Princeton University Press.

Perry, C. (1997). Admissibility and per se exclusion of hypnotically elicited recall in American courts of law. The International Journal of Clinical and Experimental Hypnosis, 45, (3), 266-79.

Person, E. S., & Klar, H. (1994). Establishing trauma: The difficulty distinguishing between memories and fantasies. Journal of the American Psychoanalytic Association, 42, (4), 1055-81.

Pert, C. (1986). The wisdom of the receptors: Neuropeptides, the emotions, and bodymind. Advances, 3, (3), 8-16.

Pert, C. (1987a). Infant observation from before birth. International Journal of Psychoanalysis, 68, 453-463.

Pert, C. (1987b). Neuropeptides, the emotions and bodymind. In J. Spong (Ed.), Proceedings of the symposium on consciousness and survival (pp. 79-89). Institute of Noetic Sciences.

Pert, C., Ruff, M., Weber, R. J., & Herkenham, M. (1985). Neuropeptides and their receptors: A psychosomatic network. Journal of Immunology, 135, (2), Supplement, 820-826.

Pezdek, K. (1995). Childhood memories: What types of false memories can be suggestively planted? Unpublished manuscript. Vancouver, Canada.

Piaget, J. (1952). The origins of intelligence in the child. New York: Basic Books.

Pillemer, D. B. & White, S. H. (1989). Childhood events recalled by children and adults. Advances in Child Development, 21, 298-340.

Piontelli, A. (1992). From fetus to child: An observational and psychoanalytic study. New York: Tavistock/Routledge.

Pitman, R.K., Orr, S.P., Forque, D.F., de Jong, J. & Claiborn, J.M. (1987). Psychophysiologic assessment of posttraumatic stress disorder imagery in Vietnam combat veterans. Archives of General Psychiatry, 44, 970-975.

Polkinghorne, D. (1989). Phenomenological research methods. In R.S. Valle and S. Halling (Eds.), Existential-phenomenological perspectives in psychology (pp. 41-60). New York: Plenum Press.

Pope, K., & Brown, L. (1996). Recovered memories of abuse: Assessment, therapy, forensics. Washington, DC: American Psychological Association.

Pope, H. G., & Hudson, J. I. (1995). Can memories of childhood sexual abuse be repressed? Psychological Medicine, 25, 121-26.

Porter, F. (1986). Neonatal pain cries: Effects of circumcision. Journal of Childhood Development, 57, 790-802.

Porter, L. S., & Lane, R. C. (1996). Iatrogenic creation of false childhood sexual abuse memories: Controversy, dynamics, fantasy, and reality. Journal of Contemporary Psychotherapy, 26, (1), 23-42.

Prescott, J. W. (1995, September/October). The origins of human love and violence. Monograph presented at the 7th International Congress of the Association for Pre- and Perinatal Psychology and Health, San Francisco, CA.

Pressman, T.E. (1993). The psychological and spiritual effects of Stanislav Grof's holotropic breathwork technique: An exploratory study. (Doctoral dissertation, Saybrook University, 1993). University Microfilms International, 6369, 9335165.

Pribram, K. H. (1971). Languages of the brain. Englewood Cliffs, NJ: Prentice Hall.

Pribram, K. H. (1982). What the fuss is all about. In K.Wilber (Ed.), The holographic paradigm and other paradoxes (pp. 27-35). Boulder and London: Shambhala.

Pribram, K. H. (1986). The cognitive revolution and mind/brain issues. American Psychologist, 41, (5), 507-20.

Putnum, W. H. (1979). Hypnosis and distortions in eyewitness memory. International Journal of Clinical & Experimental Hypnosis, 27, 437-47.

Raikov, V. L. (1980). Age regression to infancy by adult subjects in deep hypnosis. American Journal of Clinical Hypnosis, 22, (3), 156-163.

Raikov, V. L. (1982). Hypnotic age regression to the neonatal period: Comparisons with role playing. The International Journal of Clinical and Experimental Hypnosis, 30, (2), 108-16.

Rank, O. (1924/1929). The trauma of birth. New York: Harper and Row.

Raymond, S. (1987). Perinatal memories as a diagnostic psychotherapeutic tool. Pre- and Perinatal Psychology Journal, 1, (4). 303-317.

Read, J. D., & Lindsay, D. S. (Eds.). (1997). Recollections of trauma: Scientific evidence and clinical practice. New York: Plenum Press.

Restak, R. M. (1979). The brain: The last frontier. Garden City, New York: Doubleday.

Restak, R. M. (1986). The infant mind. Garden City, New York: Doubleday.

Rhodes, J. (1996). Children recalling birth. Primal Renaissance, 2, (1), 59-64.

Roedding, J. (1991). Birth trauma and suicide: A study of the relationship between near-death experiences at birth and later suicidal behavior. Pre-and Perinatal Psychology Journal 6, (2), 145-170.

Ron, M., & Polishuk, W. Z. (1976). The response of the fetal heart rate to amniocentesis. British Journal of Obstetrics & Gynecology, 83, 768.

Rossi, E. (1990). From mind to molecule: More than a metaphor. In J. K. Zeig, & S. Gilligan (Eds.), Myths, methods, and metaphors (pp. 445-472). New York: Brunner/Mazel.

Rossi, E. R., & Cheek, D. B. (1988). Mind-body therapy: Methods of ideodynamic healing in hypnosis. New York: W. W. Norton.

Ruch, H. (1986). The experience of being born as recalled in adulthood. (Doctoral dissertation, Union Graduate School, 1986). University Microfilms International, 8610343. Ann Arbor, Michigan: University Microfilms International.

Salk, L., Lipsitt, L., Sturner, W. Reilly, B., & Levat, R., (1985). Relationship of maternal and perinatal conditions to eventual adolescent suicide. The Lancet, 1, 624-627.

Sallenbach (1993). The intelligent prenate: Paradigms in prenatal learning and bonding. In T. Blum (Ed.), Prenatal perception learning and bonding (pp. 61-106). Berlin: Leonardo Publishers.

Sallenbach, W. B. (1994). Claira: A case study in prenatal learning. Pre- and Perinatal Psychology Journal, 9, (1), 33-56.

Scheflin, J. D., & Brown, D. (1996). Repressed memory or dissociative amnesia: What the science says. The Journal of Psychiatry and Law, 24, (2), 143-88.

Shanley, L. (1994). Unassisted childbirth. New York: Bergin & Garvey.

Sheldrake, R. (1982). Morphic resonance, memory and psychical research. Parapsychological Journal of South Africa, 3, (2), 70-76.

Sheldrake, R. (1987). Can our memories survive the death of our brains? In Proceedings of the symposium

on consciousness and survival. Institute of Noetic Sciences Review, 67-77.

Sheldrake, R. (1995). Nature as alive: Morphic resonance and collective memory. Primal Renaissance: The Journal of Primal Psychology, 1, (1), 65-78.

Shetler, D. J. (1989). The inquiry into prenatal musical experience: A report of the Eastman Project, 1980-1987. Pre- and Perinatal Psychology Journal, 3, (3), 171-189.

Smith, S. E. (1995). Survivor psychology: The dark side of a mental health mission. Boca Raton, FL: Upton Books.

Smith, W. M. (1988). A comparison of the breathwork approaches of Stan Grof and Gay Hendricks. Unpublished doctoral dissertation, Institute of Transpersonal Psychology, Menlo Park, CA.

Spelke, E. S., Breinlinger, K., Macomber, J., & Jacobsen, K. (1992). Origins of knowledge. Psychological Review, 9, (4), 605-32.

Stocks, J. T. (1998). Recovered Memory Therapy: A dubious practice technique. Social Work, 43, (5), 423-36.

Stumpf, S. E. (1975). Socrates to Sartre: A history of philosophy. New York: McGraw-Hill.

Sullivan, H. (1953). Interpersonal theory of psychiatry. New York: Norton.

Sutich, A. (1969). Some considerations regarding transpersonal psychology. Journal of Transpersonal Psychology, 1, (1), 11-20.

Taddio, A., Goldback, M., & Stevens, B. (1995). The effect of neo-natal circumcision on pain responses. The Lancet, 345, 291-292.

Tarnas, R. (1976). Birth and rebirth: LSD, psychoanalysis, and spiritual transformation. Unpublished doctoral dissertation, Humanistic Psychology Institute, San Francisco .

Tarnas, R. (1991). The passion of the western mind: Understanding the ideas that have shaped our world view. New York: Ballantine Books.

Tayloe, D. R. (1995). The validity of repressed memories and the accuracy of their recall through hypnosis: A case study from the courtroom. American Journal of Clinical Hypnosis, 37, (3), 25-31.

Terr, L. C. (1991). Childhood traumas: An outline and overview. American Journal of Psychiatry, 148, 10-20.

Terr, L. C. (1994). Unchained memories: True stories of traumatic memory, lost and found. New York: Basic Books.

To, T., Agha, M., Dick, P.T., & Feldman, W. (1998). Cohort study on circumcision of newborn boys and subsequent risk of urinary-tract infection. The Lancet, 352, (9143), 1813-1816.

Tomatis, A. A. (1987). Ontogenesis of the faculty of listening. In T. R. Verny (Ed.), Pre- and perinatal psychology: An introduction. New York: Human Sciences Press.

Ungar, G. (1967). Transfer of learned behavior by brain extracts. Journal of Biological Psychology, 9, 12-27.

Valle, R., & King, M. (1978). Existential-phenomenological alternatives for psychology. New York: Oxford University Press.

Valle, R., King, M., & Halling, S. (1989). An introduction to existential-phenomenological perspectives in psychology. New York and London: Plenum Press.

Valle, R., & Mohs, M. (1998). Transpersonal awareness in phenomenological inquiry: philosophy, reflections, and recent research. In Braud, W. & Anderson, R. (Eds.) Transpersonal research methods for the social sciences: Honoring human experience (pp. 95-113). Thousand Oaks, CA: Sage Publications.

Van de Carr, R., & Lehrer, M. (1988). Prenatal university: Commitment to fetal-family bonding and the strengthening of the family unit as an educational institution. Pre- and Perinatal Psychology Journal, 3, (2), 87-102.

Van den Bergh, B. R. H. (1990). The influence of maternal emotions during pregnancy on fetal and neonatal behavior. Pre- and Perinatal Psychology Journal, 5, (2), 119-130.

van der Kolk, B. A. (1989). The compulsion to repeat the trauma: Reenactment, revictimization, and masochism. Psychiatric Clinics of North America, 12, (2), 389-411.

van der Kolk, B.A. (1994). The body keeps the score: Memory and the evolving psychobiology of post traumatic stress. Harvard Review of Psychiatry 1, 253-265.

van der Kolk, B. A. (1996). The body keeps the score. In B. A. Van der Kolk, A. C. McFarlane, L. Weisaeth (Eds.), Traumatic stress: The effects of overwhelming experience on mind, body and society (pp 1-37). New York: The Guilford Press.

van der Kolk, B.A. & Ducey, C.P. (1989). The psychological processing of traumatic experience: Rorschach patterns in PTSD. Journal of Traumatic Stress, 2, 259-274.

van der Kolk, B.A. & van der Hart, O. (1991). The intrusive past: The flexibility of memory and the engraving of trauma. American Image, 48, (4), 425-454.

van Kaam, A. (1966). Existential foundations of psychology. Pittsburgh, Pa.: Duquesne University Press.

Verny, T. R. (1987). Pre- and perinatal psychology: An introduction. New York: Human Sciences Press, Inc.

Verny, T. R. (1992). Obstetrical procedures: A critical examination of their effect on pregnant women and their unborn and newborn children. Pre-and Perinatal Psychology Journal, 7, (2), 101-112.

Verny, T. R., & Kelly, J. (1982). The secret life of the unborn child. New York: Dell Publishing.

Verny, T. R., & Weintraub, P. (1991). Nurturing the unborn child. New York: Delacorte Press.

Vlcek, J. (1989). Journey into the world: My life before birth. Don Mills, Ontario, Canada: Elf Publishing.

Vlcek, J. (1993). My first heartbeat. Pre- and Perinatal Psychology Journal, 7, (4), 317-320.

von Eckartsberg, R. (1986). Life-world experience: Existential-phenomenological research approaches in psychology. Washington D. C: University Press of America.

Wade, J. (1996). Changes of mind. Albany, New York: State University of New York Press.

Wagstaff, G. F., & McGuire, C. (1983). An experimental study of hypnosis, guided memory and witness memory. Journal of the Forensic Science Society, 23, 73-78.

Wakefield, H., & Underwager, R. (1994). Return of the furies. Chicago and La Salle, Illinois: Open Court.

Wald, G. (1984). Life and mind in the universe. International Journal of Quantum Chemistry: Quantum Biology Symposium, 11, 1-15.

Wambach, H. (1979/1981). Life before life. New York: Bantam Books.

Weber, R. (1982). The physicist and the mystic is a dialogue between them possible?: A conversation with David Bohm. In K. Wilber (Ed.), The holographic paradigm and other paradoxes (pp. 187-215). Boulder and London: Shambhala.

Wellington, N., & Rieder, M. J. (1993). Attitudes and practices regarding analgesia. Pediatrics, 92, (4), 541-543.

Wertz, F. (1984). Procedures in phenomenological research and the question of validity. In Von Eckartsberg, R. (Ed.), Life-world experience: Existential-phenomenological research approaches in psychology (pp. 83-97). Washington, D.C.: Center for

Advanced Research in Phenomenology and University Press of America

Whitehouse, W. G., Dinges, D. F., Orne, E. C., & Orne, M. T. (1991). Distinguishing the source of memories reported during prior waking and hypnotic recall attempts. Applied Cognitive Psychology, 5, 51-59.

Wilber, K. (Ed.) (1982). The holographic paradigm and other paradoxes: Exploring the leading edge of science. Boulder and London: Shambhala.

Williams, L. M. (1992). Adult memories of childhood sexual abuse. American Society for Prevention of Child Abuse Advisor, 5, 19-20.

Williams, L. M. (1994). Recall of childhood trauma: A prospective study of women's memories of child sexual abuse. Journal of Consulting and Clinical Psychology, 62, 1167-76.

Williams, L. M. (1995). Recovered memories of abuse in women with documented child sexual victimization histories. Journal of Traumatic Stress, 8, 649-73.

Winnicott, D. W. (1949/1958). Birth memories, birth trauma, and anxiety in collected papers: Through paediatrics to psychoanalysis. New York: Basic Books.

Wolfgram, C. & Goldstein, M.L. (1987). The search for the physical basis of memory. Bulletin of the Psychonomic Society, 25, 1, 65-68.

Woody, C. D. (1986). Understanding the cellular basis of memory and learning. Annual Review of Psychology, 37, 433-493.

Yapko, M. D. (1994a). Suggestibility and repressed memory of abuse: A survey of psychotherapists' beliefs. American Journal of Clinical Hypnosis, 36, (3), 163-171.

Yapko, M. D. (1994b). Suggestions of abuse: True and false memories of childhood sexual trauma. New York: Simon & Schuster

Yassky, A.D. (1979). Critique on primal therapy. American Journal of Psychotherapy, 33, (1), 119-27.

Zaner, R. M. (1970). The way of phenomenology. New York: Pegasus.

Zelig, M., & Beidleman, W. B. (1981). The investigative use of hypnosis. International Journal of Clinical & Experimental Hypnosis, (29), 401-12.

Zohar, D. (1990). The quantum self. New York: Quill/William Morrow.

APPENDIX A

A Consent Form for Participation in Research on
the Experience of Healing Through the Remembrance of
the Pre- and Perinatal Realm of Life

To the participant in this research:

You are invited to participate in a study which examines the phenomenon of healing through the remembrance of the pre- and perinatal .

If you have had this experience and are willing to participate in the project by sharing it in written as well as oral interview form, you will be given the materials to do so. You will also receive a follow-up contact or call wherein you will be asked to compare your experience with the results of the data analysis. The time spent on the written section is dependent upon your sense of what is necessary to answer the question, but will probably take 1 to 2 hours. The oral section also will take between 1 to 2 hours depending upon the nature of our interaction. The time and location of the interview will be arranged at a later date.

For the protection of your privacy, all information received from you will be kept confidential and your identity will be protected. The audio tapes from the interview session and all written material pertaining to this study will be kept in locked file cabinets and will be accessed only by the researcher. A pseudonym can be used to identify you during the taping session and on all written documents. In the reporting of information in published material, any information that might identify you will be altered to ensure your anonymity.

There is benefit to you of increased self-understanding by participating in this project as well as your contribution to the advancement of scientific knowledge. This study is designed to minimize potential risks to you, however, the memory of birth can give rise to feelings of fear or other discomfort. If at any time you have concerns or questions, I will make every effort to discuss them with you, and inform you of options for resolving them.

Please feel free to call me collect regarding this study at 707-792-2663. You may also contact Michael

Hutton, Ph.D. (Dissertation Committee, Chairperson) or Robert Schmitt, Ph.D. (Academic Dean and Head of the Ethics Committee for Research at the Institute of Transpersonal Psychology) at 650-493-4430. The Institute of Transpersonal Psychology assumes no responsibility for psychological or physical injury resulting from this research.

If you decide to participate in this research, you may withdraw your consent and discontinue your participation at any time during the research stage without penalty or prejudice. You may request a summary of the research findings by providing your mailing address beneath your signature.

I attest that I have read and understood this form and have had any questions about this research answered to my satisfaction. My participation in this study is entirely voluntary. My signature indicates my willingness to be a participant.

Participant's signature Date

Researcher's signature Date

Mailing address (required for summary of research findings)

APPENDIX B

Questionnaire for the Written Protocol of: What is the Experience of Healing Through the Remembrance of the Pre-and Perinatal?

Instructions:

Select a time and space where you can be alone, uninterrupted, and relaxed. You might want to play some favorite background music or sit in meditation for a while. Have a pen and paper nearby.

1. Begin by becoming very comfortable...very settled. For the next hour or so there is no place to go, nothing to do except allow yourself this time of introspection. As the thoughts of the day are gently placed aside, begin to remember those times when you remembered or reexperienced your birth,before and/or after it. Take as much time as you need to come into connection once

again with the perinatal realm.

2. As you regain these memories, try to remain very open to everything that comes to you, staying with the experience itself. Allow your feelings to surface as if it were the first time.

3. When you feel complete in this process please write of your experience. Try to describe the feelings you had just as they were, so that someone reading or hearing your description would know what happened, just how you felt and what your thoughts and images were.

4. Please do not stop until you feel that you have described your experience as completely and as fully as possible.

APPENDIX C

Hycner's Guidelines for the Phenomenological Analysis Of Interview Data

1. Transcription.

Interview data will be transcribed and herewith referred to as protocols. There will be a large right-hand margin for noting significant non-verbal and para-linguistic communications. (A follow-up interview will be conducted by reading back the transcribed material to the co-researcher. Further, a follow-up question will be asked.)*

2. Bracketing.

Prior to each interview, the researcher will endeavor to bring to consciousness her ideas, beliefs, experiences, opinions, expectations, interpretations, etceteras, pertaining to the experience in question. Further, maintaining my responses to the co-researcher In suspension, that is, holding them in awareness, will allow a more thorough, unbiased and open reception of the forthcoming data.

3. Listening to the interview for a sense of the whole.

This step requires the researcher to immerse herself into the interview by listening to it several times in order to get a sense or a feel for its gestalt or wholeness. Notes should be taken at these times and special attention paid to non-verbal and para-linguistic levels of communication.

4. Delineating units of general meaning.

General meaning units are those words, phrases, non-verbal or para-linguistic communications which express “unique and coherent” meaning, irrespective of the research question.

5. Delineating units of relevant meaning.

To the units of general meaning, the researcher will apply the research question. If the unit responds to and illuminates the research question, it becomes a unit of relevant meaning.

6. Consulting with an independent researcher for validation.

The researcher will then train an independent researcher, familiar with phenomenological research, to utilize these guidelines on the first set of interview data and compare those results with hers. If there are significant differences in the findings, the researcher will advise the committee and request guidance. Slight variations between the two explications will suffice as sufficient validity. The researcher will proceed with Step 7.

7. Eliminating redundancies.

The researcher will then eliminate obvious redundancies taking care not to remove items used repeatedly but with different intended meanings.

8. Clustering units of relevant meaning.

The next step is to identify natural clusters, those meaning units that have a common theme or essence.

9. Determining themes from meaning clusters.

The researcher will then grasp central themes from the meaning clusters.

10. Writing a summary for each individual interview.

A summary for each interview will be made, at this point, incorporating the central themes. This summary will then be sent to the co-researcher who is free to comment on its validity or to request a second interview. If they feel there are other feelings or issues pertaining to the research question that require exploration, a second (third)* meeting can be arranged.

11. Returning to the participant with summary and themes: conducting a second (or third)* interview.

Assure that the co-researcher feels that the essence of the first (second)* interview reflects the essence of the experience. Conduct another interview or make corrections as needed.

12. Modifying themes and summary.

New data or corrections will then be analyzed in the same manner as previous data and any additions or modifications will be made to the summaries.

13. Collecting the completed demographics forms and summarizing.*

Information regarding the domestic situations of the co-researchers will be identified.

14. Identifying general and unique themes for all interviews.

Themes common to most or all interviews will then be identified, as well as individual variations.

15. Contextualization of themes.

This is a discussion of the context from which each of the common themes arose, giving proper perspective to its origin.

16. Composite summary.

This step renders a summary which captures the essence or structure of the phenomenon being studied. Significant individual differences will be noted.

*Parenthetical additions reflect this researcher's modifications to Hycner's guidelines.

APPENDIX D

Letter to Participants

February 11, 1998

Dear Co-researcher,

Please find my summary of your perinatal experience enclosed with this letter. I would like to know if you feel I have presented your story accurately and fairly. You are free to respond to this request by either making notes on the attached summary or by setting up a time for us to talk. Please find also a self-addressed, stamped envelope for your convenience. If you have used other than a pseudonym so far, and you would like to pick a pseudonym at this point, please feel free to write it into your response.

I would like to take this opportunity to thank you very much for the time and effort you have so generously invested in this project to date. I know that relating this intensely personal material has not been easy. For me, a part of the reward for doing this work and sharing it as you have is knowing that others may become more aware of its relevance.

My project is in its final stages. I will be sending along a summary of the results, probably by floppy disk, before the end of the Spring, 1998 school quarter. Please contact me with any questions or comments. Thanks again.

Sincerely,

N. Anne Marquez

APPENDIX E

Second Letter To Participants

February 14, 1998

Dear co-researcher,

Please take a moment to complete the enclosed demographics form. The information you provide will be held in the strictest confidence. It will be used to help evaluate the data you have already provided.

Feel free to add any information about your birth or upbringing that you think might be pertinent. A self-addressed, stamped envelope is enclosed for your convenience.

Thank you very much for your assistance.

Sincerely,

N. Anne Marquez, LCSW

APPENDIX F

Demographics Form

Name or pseudonym:
Date of Birth:
Place of Birth:
Race:
Religious Preference:
Highest Level of Education Completed:
Occupation/Profession:
Marital Status:
Type of Birth per Hospital Records: (examples: normal; breech; forceps; c-section; multiple; premature; "blue baby" or needing oxygen at birth; previous fetal demise; was anesthetic used? If so, what type? complications (please explain)).

Was any type of abuse occurring in your home as a child? (e.g. emotional, sexual, physical, or neglect.)

Did either or both of your parents have an addiction? e.g. alcohol, nicotine, drugs, food, sex, gambling etceteras.

Was chronic mental and/or physical illness present?
(please explain):

Was there a divorce, separation, or the death of
either or both your parents while you
were growing up?:

Was there a shortage of food, clothing, shelter,
physical care, or emotional
nourishment in your home?:

Were you adequately protected?:

APPENDIX G

Advertisement

The advertisement below was on the internet, the bulletin board at the Institute of Transpersonal Psychology, Open Door, Primal Spirit Magazine, and in Connections (Institute of Noetic Sciences).

A study on the remembrance of the perinatal realm of life is missing two or three special individuals. These people must have remembered some aspect of their perinatal experience, e.g. conception, birth or shortly afterward, using any method or none at all. The experience must have resulted in a clearly identifiable change in some condition, such as: the alleviation of asthma, migraines, phobias; or the discovery of sexual or physical abuse, or adoption, etceteras; or a newly gained ability to complete a goal or task. Please contact Anne Marquez, collect at (707) 792-2663.

APPENDIX H

A Letter From Karlton's Optometrist

APPENDIX I

Protocols or Life-Texts

Marisa

Interviewer: What was your experience of healing through the remembrance of the pre-and perinatal?
Marisa: I had had an experience of myself as a soul prior to birth. Hanging out in the universe. And my recollection is almost a visual one of hanging out in a little egg of light out in the midnight blue sky. Stars all around. And I felt very safe and warm and sure of my purpose in coming to earth. I knew I was going to come to earth. And the purpose was a small one but it meant a lot to me. And that was to bring light to the earth. Light of healing, compassion and love. It's not anything big and grandiose. I didn't suspect I was going to be known by anybody or anything like that. I would give this gift to a few people.

My first recollection came after I had done several birth regression experiences. But the first which came chronologically was of my mother's egg and my father's sperm. And my experience of it was that they both had alcohol in them. And that they were coming together not out of desire and intention but by accident. And my dad was drunk I immediately felt that this was wrong.

So I immediately had this feeling that it was like the wrong place, the wrong people, the wrong time. My parents were drunk and the egg and sperm came together in this kind of nauseating, smelly kind of alcohol-soaked womb. And so they did come together and I guess my light and my purpose were strong enough to make it take...to make the two come together and form one. Even though part of me was saying, "No, no, not this one!"

And so I worked down the fallopian tube in the dark feeling terrified about what this ride was gonna be like. And dropping into the womb there was immediately a sense of darkness. A sort of goo-like gloppiness. And this image is like one I once saw of the inside of the lungs of a heavy smoker. And there was literally tar all around the little hairs, the cilia or whatever they're called that line the lungs making them look , I don't know, like

grasses in the sea that are polluted by an oil spill. And that was the image I had of what my mother's womb was like...that it was all black tarry stuff and it was almost impossible to see and to survive 'cause it really smelled bad, and tasted bad. So I had to stretch within myself profoundly to try to attach myself. I did that. But it was very difficult to do. And I tried over and over and over and over again and I just couldn't get through to anything because of all the tar and gunk. And I nearly gave up. And finally just one more time I tried. I did attach that time and just sort of hung there. And after a while I became aware of another being with me. And I moved over enough so I could see her and I was really glad to know she was there. I found out quickly that she was even weaker and more scared than I was. She was really having a hard time...staying alive. And as we continued to grow I was just totally in love with her. And I felt desperately that I needed to take less to give her more. And I tried to do that but nevertheless I got bigger and she...she just got sicker. And eventually she died and kind of fell away from me. And I have a strong visual of that as being this totally heartbreaking moment. And I felt this enormous crushing loss. It was just devastating.

So then I continued to hang out in there and grow. And I never lost the sense of it being polluted and of my life being in danger. I was like...felt really assaulted. My mother thought she might be pregnant. She didn't want to be pregnant. She already had a 9 month old baby. And it was just after Pearl Harbor. Everybody was lining up to go into the Army or Navy or whatever. My mother knew that my father wouldn't be around and she was terrified that he would be killed. She was certain that he was going to leave her and she didn't want to be a mother at all, let alone be a mother of two. And she had really loved her job. She worked for a Washington politician and she was really intimate. And, she may have even had an affair with him. I'm not sure. But anyway, she went to the doctor and found out she was pregnant. And on the way back she was standing by this streetcar line and thought about it and almost did throw herself under the streetcar. And I just felt really awful that my mother would prefer to die rather than have me. And I never

got over that.

And the most devastating part of that memory was that I had reenacted that with my own daughter by attempting suicide when she was 3. And I nearly died. And so I felt a combination of my own loss and guilt that I had done the same thing and a deep understanding about what my daughter's suffering around that has been like. And it has been huge.

So, my father's response to the pregnancy I hardly recall. It wasn't much of anything. He was really dead to his feelings. And the feeling that was waiting to come up for him was fear but...he didn't really feel that. He was shut down totally.

And so my mother spent the rest of the pregnancy laying on the couch with a maid taking care of my brother. She was drinking and smoking. And I completely forgot about carrying the light. And the only thing that was positive at all for me was looking forward to knowing my brother. He was a sweet little guy. He was very ill with asthma and he constantly had to be rushed to the hospital. Not constantly, but it happened a number of times. He also had surgery for pyloric stenosis as a baby. He was very, very sick but he was a sweetheart. We really needed each other.

So I just hung out in the womb in a toxic environment. My feeling was that my mother was trying to kill me in a sort of passive way. So I was very, very sad and I just felt very strongly that I wasn't wanted. So I just tried to be very quiet and quote "good" unquote, so that maybe if I didn't cause her any problems she would love me.

Finally at 7 1/2 months I really couldn't tolerate the environment anymore. And I just gathered all my energy to support this feeling that I had to get out of there. That was another feeling that's lasted all my life. And so I just really put an enormous amount of effort into trying to get born. It was my initiative and I started the process and kept trying to come out. And it was really, really difficult and really long 'cause my mother was so afraid and shut down and negative about the whole thing.

She told the doctor, and I remember this...I remember his white coat. That she didn't want to feel anything. And she wanted him to knock her out. And when the baby

was born she wanted somebody to tell her if it had the right number of fingers and toes and that was all she cared about.

And so he did knock her out. I didn't get any help at all. And it was really, really, really hard. 'Cause I was poisoned and toxic to start out with and I was going on adrenaline, period. But you know a life and death struggle gives a person a certain amount of strength so I did persevere and continue to push. Finally, it seemed like even though she was drugged, I was drugged, and it was hopeless, I was making progress. And I was just about out of there.

The next thing I remember is feeling these cold metal instruments grab around my head and pull on me. And it was so infuriating to me. I really wanted to just rip the doctor's head off. I've never felt such rage in my life. When this came up in a birthwork session I felt like I could just rip the whole place down because I felt like my experience was taken away from me. And I had done all the work. And then I didn't even get to get born. This man just ripped off my triumph.

So then I was just on this white sheet or something with white lights, bright white lights. And I was wet and shivering. And I remember just lying there and being silent. I really wanted my mother to pick me up and comfort me after the ordeal I had been through. And I just desperately needed some human contact. She didn't pick me up. And she didn't say anything. And nobody said anything. And I was totally all alone there and I started to cry. And finally I made this bargain which was if she would just pick me up then I would die for her later.

Interviewer: You mean get out of her way?

Marisa: Yes.

So anyway, someone, not her, did pick me up...and left me in the nursery. And I remember seeing my father at the nursery window, standing there looking really sad with tears in his eyes. And I made a bargain with him. Which was if he would love me I would take care of him.

So after that I don't really have any other memories. Oh yes, I remember a nurse...a stocky nurse in a starched white uniform, being held against her big white chest and taken into my mother's room. The nurse asked my mother if she wanted to hold me. And she said, "No," that she just wanted to sleep. I remember

feeling that the nurse had a judgment about that and felt that I was in for a rough time. And it helped that the nurse had some feelings about my mother's behavior.
Interviewer: That was validating to you?
Marisa: Yes. So that was it.

Douglas

Interviewer: What was your experience of healing through the remembrance of the pre- and perinatal?
Douglas: I didn't have any memory of any birth trauma or trauma for 35 or 40 years. So I didn't know anything about it. And what brought me to dealing with it was the need to deal with my body and my feelings in deeper and deeper ways, because I was depressed a lot and I felt really lonely and isolated from the world. Pretty dissociated and detached though I probably wouldn't have labeled it that 'cause I didn't know anything different.
Interviewer: You didn't recognize it?
Douglas: Yeah, right. You don't think about the air you breathe that much, you know? So, but I did sense that I was depressed but didn't really know why. And then I got into regular talk therapy and eventually got into primal therapy and stuff, trying to resolve the feelings of isolation and loneliness and depression that I had...that I particularly was aware of as I went into college. And part of that time I'd always been a super-achiever and in reflection I realize I was just trying to prove I was okay. Cause I didn't feel like I was okay.

And so several things happened but the brunt of it hit about 6 years ago, for me. I had heard about birth trauma. Hadn't really had any experiences with it. I'd been involved in primal therapy and didn't really have any early birth trauma experiences. But then, about 6 years ago, I was working in a mental hospital as a therapist and I was assigned a young man who had a psychotic break. And for 3 months I did everything I knew how to do to connect to him. And in that 3 months he never made eye contact with me. And I was grabbing him, talking to him, wrestling with him, bumping him, singing to him, anything I could think of to engage him. And he just wouldn't engage. And finally what we

did was we put him in a halfway house for the chronically mentally ill. We kinda gave up, cause we didn't know what to do.

And that triggered a depression for me that lasted 2 years. So, I...it was debilitating. I was suicidal every day and I couldn't get up in the morning. Didn't want to get up in the morning. Wanted to be dead. Didn't care about anything. The only way I survived was with credit cards. So I lived off my credit cards for 2 years.

Interviewer: You couldn't work?

Douglas: Couldn't work...just a little bit. Like one fifth of what I was doing prior to the depression. Just enough to keep things going. And uh, just really scared, didn't want to be around people. I was afraid of people. Just felt terrible. And that just dragged on and on. I was in therapy three times a week. I was crying all the time. I was on Prozac. Nothing touched my depression. Without the Prozac I felt like I was dog-paddling out in the middle of the Atlantic Ocean by myself. And with Prozac I felt like I was standing tippy-toe in the middle of the Atlantic someplace. But at least my nose was out of the water and I had something underneath me. And it still was pretty uncomfortable. [laughs] You know if I relaxed and just stood flat-footed I'd go under. You know it was that much on the edge.

Interviewer That's a great analogy.

Douglas: It was terrible.

So, um, I found a retreat center that deals with therapists in crisis. And I put myself in that retreat center. It's like an inpatient place for therapists that are messed up. So that sounded like the place for me. So I went and put myself in this place. And fortunately, they knew a lot about pre-and perinatal psych. They were very good at dealing with very sensitive feeling states. And they were also very good at dealing with the biggest rages you can imagine.

Interviewer: What was the name of it?

Douglas: It was called Pocket Ranch. Barbara F.? Star? So I put myself through that and the combination of their program helped me feel safe enough to go into my real early memories and wounds.

And while I was there I recovered the memory of almost dying at my birth and remembering how excruciating it was. And how I almost

died and wished I would die. Because it was so painful. And I remembered a 36 hour labor and feeling like I was being crushed to death. And in fact my mother did crush a baby to death before me. Her first baby died in the womb from just birth trauma. And my sense was that he kinda paved the way for me. He kinda loosened her up enough so that I could come through. She was a very short, stocky, muscular woman and she was terrified. So, she just clamped down and just crushed the babies. And for her, she told me the experience with her is she felt like she was dying. You know it was really horrible for her too. And heavy anesthesia was used. And...as well as forceps. And I had bonding trauma because she didn't hold me afterwards. And I was put in some sort of bassinet or something by myself. And it was cold and nobody was there. It was just like one trauma after another after another after another. So there's lots of little pieces. I have memories of being anesthetized and how that affected me in my life. I have memories of forceps and how that impacted me. I have memories of the bonding stuff, about my mother not bonding to me. So all those have themes in my life that have been real profound. For example it's been interesting how they've been triggered in my life and where I've had to deal with them. You know cause each of these things that I've remembered and worked through has come at different times in my life as I've recovered different pieces for myself. When I was up at that ranch, I really got in touch with how excruciating it was to be born, and how isolated and lonely I felt having a mother who couldn't, wouldn't connect to me. And how isolated and lonely, and forlorn I felt. Which then that feeling stuck with me my whole life. That's very sad. Very sad. Which is interesting because after I did that experience at the Pocket Ranch and really connected with why I felt the way I did, the depression was replaced with a deep sense of grieving. And I found that unless...cause I would wake up every morning wanting to be dead. And if I gave myself the time and space to have my feelings and grieve, from 10 minutes to 30 minutes I would be fine and I could go on with my day and do what I needed to do. But if I didn't I would be depressed the whole day. So what I realized was that I might have to grieve every morning of my life in order to feel okay. And I made the

decision, well if that's what I have to do, that's what I have to do. And the grieving process lasted almost daily from a year to a year and a half. And then it just got like it emptied that primal core of pain and I didn't need to do that much anymore. And now depression is hardly with me. The other thing that was really profound when I was at that ranch was connecting to the memory of being in utero and realizing my mother didn't want me. And then she was still in mourning about the loss of her first child but she had never mourned that child. So she was full of grief and I was marinating, as I was cellularly growing, in her grief. And it was almost as though it impregnated me with her grief and then also left me grieving because she didn't really want me she wanted a replacement for the other child. So she wasn't really looking for me. She wanted that other child to come back. And so it left me feeling unseen...unwelcome. And so that was just another deep piece of grief for me.

Interviewer: A part of the depression?

Douglas: Right. Part of my deep depression was involved with anesthesia. And how I realized that was tied in is that I was still going through a lot of depression a number of years ago. And I would get depressed and I would sort of fade out. Like I could be at a workshop for example and I couldn't stay awake. And I would just literally go unconscious. And I kept on going unconscious. And then actually William worked with me. And he recreated the pressure on my head that was similar to the pressure I felt at birth. And also the pressure of forceps especially over my right ear where the forceps were really cramping hard. And what it did is it triggered the memory of the forceps but also it triggered the memory of being anesthetized to the point where I left my body and numbed out. And lost connection with my resources to fight or flee. And with him applying a lot of pressure over my right temple and ear it triggered that desire to fight or flee...the intensity. And at that point I started connecting up my depression and sleepiness to being anesthetized and being chemically severed from my ability to fight the situation or flee from it due to going into dissociation and numbness. And that was a big piece 'cause that helped relieve another chunk of the depression once I got that piece.

Yeah it was interesting cause if we go back even 15 years earlier than this. I was in primal therapy. I was very distressed and I was suicidal then too. Though not as actively as I was when it really hit me like 6 years ago. But I was in primal therapy, and... which they're very open to feelings, which was good for me. And what happened in the course of that therapy is 1 day I was taking a hot shower and the next thing I realized I was waking up on the bathroom floor with the shower curtain ripped down and the water still running in the shower. Not knowing how I got there. So what had happened, I had gone from standing up washing my hair and letting the hot water on my head to being unconscious and waking up on the floor. Totally freaked me out. I had no idea what had happened.

So what was happening was I was feeling my feelings enough. Of course the therapy was opening up to my feelings more. And then you know 1 day seemingly unrelated to my therapy I was just taking a normal shower and I blacked out. And this had never happened to me before. So it was as if part of that... I was so locked out emotionally that I was real... I was very muscular. I had been a nationally ranked gymnast, and worked out a lot. I was very involved in gymnastics and competition. So I was very tight and muscular. And in a way that helped me defend against my pain. But then after I got into therapy the therapy was a way to help me start expressing all the tension I had in me. Cause there was just a lot of repressed feelings. And so as I would express my feelings more my defense layers would kindof shrink down and I was more exposed to my feelings including these feelings of blacking out, which at the time seemed bizarre. But what I started realizing is that I could start to feel the black-out coming on.

It always occurred in the shower, which seemed bizarre. And sometimes it wouldn't happen. But other times I'd be...and it would always happen when I was running the hot water on my head and shoulders. Particularly my head. And my neck. So as it happens I started realizing that I could feel it coming on. And sometimes it would come on real quick and sometimes more slowly. But I would go from having no symptoms at all to being fully unconscious in anywhere from 2 seconds to 10 seconds. And what I learned is that if I

squatted down real quickly in the tub I wouldn't faint...out fully. Sometimes I would loose my vision. I would black out. But I would still be conscious. My vision would go black but I would still be conscious that I was in the tub on my hands and knees hanging my head down. And then slowly it would go away. And I would slowly get up and resume my shower. And it started making sense to me after a while...cause this happened over the course of the year and a half, maybe 25 times, 30 times.
Interviewer: I'm surprised you kept on taking showers.
Douglas: [laughs] So, it would only happen about once a month or twice a month you know. But it was funny cause there was something familiar about it? It was really scary at first but there was something that attracted me to it at the same time. It was bizarre. I didn't understand it.
Interviewer: Maybe you recognized it?
Douglas: Yeah something about it seemed familiar. So a friend of mine was a therapist, a primal therapist. And so I talked him into coming over one day. So I put on a swim suit, got in the shower and turned on the water as hot as I could stand it. And sure enough, the feelings came up. And we had made a little nest on the bathroom floor of towels and blankets and stuff. And so as soon as the feelings came on I'd say, "The feeling's coming on." And he'd help me get out of the shower real quick, lay down on the floor, and go into the feeling. And I just went right into the feeling. And it was the feeling of being born and having my head crushed and having so much pressure on my entire body from my mother just clamping down that I would fight and fight, struggle and struggle, and try to push. And I would be in a rage trying to get out cause she wasn't helping me. And the intense pressure along with the intense rage I was having then I would black out. It would finally get too much for my nervous system and I would just black out. And so I went into those feelings there on the bathroom floor of just like raging and blacking out, and then raging and then blacking out and then crying, crying and then raging and then blacking out and then crying and just cycling through these feelings. And then finally the raging and the crying went away. And then I probably had to do that another...you know take a shower and let the

black-outs start to come on, I had to lay down on the floor maybe another half a dozen times after that. And then it hasn't happened since. Now that was 15 years ago. No that was more like 20...25 years ago.

So let's see. I think the thing that was really interesting...this ties in with the flying story. I was in gymnastics from 7th grade till into my sophomore year in college. And I was really into it. I was very competitive and I was very good at it. Except I was never good at tumbling or flipping or twisting. Whenever I had to let go of something and flip or twist I would freak out. And I did a lot of things where I would...I remember trying to do a double back flip off the rings and getting disoriented and landing on my head. And several times off the high bars trying to do a layout flyway off the bar and I would lose my orientation and I would rotate 2 1/2 times instead of 1 time and land on my head. So I kept on really damaging myself in a pretty profound way. And I finally...it really inhibited me in gymnastics because to do really nationally ranked routines you have to do a lot of flips and twists. And I was really, I was very strong and really agile and so forth, but when it came to flipping and twisting I would just lose it. I just would get disoriented and... And in retrospect I realize I went into an immediate panic whenever I let go of the apparatus and start to twist I would go into immediate terror. But I experienced it as just kindof blacking out and not understanding what was going on and just figured I was a scaredy-cat or something. And so, I ended my gymnastics career in college and then skipped forward
twenty years. I just felt like I ran into this block and I couldn't get any better. I was about as good as I could get in gymnastics without getting that piece resolved. So it was frustrating.

So if we move forward 20 years now. I haven't done gymnastics for 20 years for the most part. But I still felt driven to learn how to flip and twist. So I went back and got back in shape and competed in the Senior Olympics.

Interviewer: What is the Senior Olympics?

Douglas: It's just for more mature athletes you know to compete against each other. So I went back and did that. And my intention was to learn how to flip and tumble. So I went back in gymnastics but the neat

thing about it...
Interviewer: You don't give up do you? [laughs]
Douglas: Yeah, I'm pretty tenacious. [laughs] But I was driven to do it. I didn't consciously know why. I just, I knew I wanted to master flipping and twisting. And the neat thing about 20 years having elapsed in gymnastics is now instead of having mats 2 inches thick that you would tumble on and stuff, they now have crash pads 4 feet thick that you can land in. No matter if you land on your head or not you still wouldn't get hurt. So it was like "all right!" It was like safer for me to explore tumbling and twisting knowing I wasn't gonna get hurt. So I was able to kindof move into it at my own rate. I was still really scared of it. But I was able to move into it and I started learning how to tumble and twist.

But that new gymnastics exploration ended cause I was doing an under bar flip on the parallel bars and I hit my foot on the upright of the bars and broke my toe. And so I couldn't run as easily anymore to do the tumbling or the twisting. But I was still driven to learn how to tumble and twist. And also it was really hard to do gymnastics cause only doing it once or twice a week I kept on pulling muscles. To do gymnastics competitively you have to do it five or six times a week otherwise you just keep on getting injuries. And I couldn't keep up with that with being a professional. So, I thought, "Well, how else can I do tumbling and twisting?" So I thought, "Okay, I'll learn how to fly aerobatics gliders." So that means airplanes without engines but they can do flips and turns and twists. But the closest aerobatics airport with gliders was like a 2 hour drive from LA So I thought, "Well, I'll learn how to fly engine airplanes. That'll teach me how to fly. Then I can fly to the glider port and then fly the glider."
Interviewer: So your first thing wasn't to learn how to be a pilot?
Douglas: No, that was a secondary thing. Totally secondary thing. I was really driven to do it. So, I learned how to fly. And it was really scary. The whole thing scared me a lot. But I kept on. I went at it very slowly. And so I went at my own pace which is maybe one of the first times I'd ever done that. Always push, push, pushed myself before. But with flying...Some people get their pilots license in 3 or

4 months. I took 4 years. I just really took my time. And I was really afraid of it. And I was a white knuckled commercial flyer you know. So to fly myself was like really a challenge.
Interviewer: Was it almost phobic?
Douglas: Oh yeah. It was like I was being counterphobic in a way, you know, by taking this on. So I learned how to fly. And then I had an opportunity to get my instrument license. And I was really attracted to that too because in instrument flying you could be in a total fog bank and you can know your orientation by looking at your instruments. There's something about that that appealed to me. You know I could figure out where I was in space by just looking at these dials. I thought, "Well this is cool." So in the instrument training one of the things that they do is they put a hood on you so you can't see outside. And then the instructor puts the plane in unusual attitudes. You know segues and turning and dives and climbs. And then he says, "Okay, open your eyes and read your instrument panel." And you're not able to see because of this hood. And you have to figure out what the plane's doing in space and correct it. You know if it's diving you have to move it up so it's a straight level. Or if it's climbing on the edge of a stall you have to drop it down.

And so the first time he did this with me and said, "Okay, it's your plane." You know, "Make it fly straight and level." I just freaked. I just went into immediate error. I knew I was gonna die. I didn't even get that he was there with me. You know it was just like, "Ahhh!" Just terror. And I came down. I just said, "I'm not doing that one again. Forget it."

And so that night after the flight I awoke at like 2 or 3 in the morning from a deep sleep. I just went, "panicky inhale." I just woke up. Just like that. And it was like a nightmare except that there were no images. There were no symbols, just pure terror. After a couple of minutes I realized that I was in a feeling. I'd been in therapy enough in my life to recognize this was a feeling. So I ended up just laying down on the floor and breathing into what the feeling was. And immediately I just went into this shaking and crying and just terror. And immediately this image of my father popped into my mind, of him

grabbing me and throwing me across the room and me going backwards. And I was flying through the air, thinking, "How am I going to land safely?" And so I felt that feeling and cried and shook and went through that. And then I just had this tremendous sense of relief after that.

And then when I went up flying the next day with my instructor I had him put me in unusual attitudes again. But the first time I did it without the hood. I said, "Okay, I need to work into this slowly. This terrifies me." And so he worked with me. He let me take it one step at a time. And then I would go home at night and feel my feelings about the terror and about being thrown by my father.

Interviewer: It was a memory of being thrown across the room by your father?

Douglas: Yeah when I was an infant, you know. And I don't know how far he actually threw me. It might have only been 2 feet you know, throwing me into a sofa or, I don't know.

Interviewer: Have you ever checked that out with him?

Douglas: No. I don't really have a need to 'cause I know it's real for me, you know? I've confronted him on other things and I don't really have a need to do that at this point. And we have a pretty good relationship now and he's admitted to me and apologized for being as crazy as he was when I was a child. I don't really need to do much more than that at this point. Which is nice, cause I feel differently about my mother. [laughs] But that's another story.

So, as I kept on going through the instrument training and kept on pushing the limit, with...getting more and more into the unusual attitudes with the hood, and having the plane be sort of out of control and getting it under control. I also retrieved a memory of ...you know when I went on the floor one day...of being born and being held upside down and having that feeling of vertigo and just went, "Ahhhh! What's happening? What are you doing? Are you gonna drop me?" And so it was retrieving that memory of being held upside down at my birth where I was held upside down and spanked because I wasn't breathing. And so that was also entwined with that feeling of vertigo, being out of control, terrified.

Interviewer: That memory came up while you were flying?

Douglas: Yeah that was actually flying. But one evening after flying when I was feeling real agitated and upset and I laid down on the floor and just let myself breathe into my feelings. And the feeling again went into terror and then went into the memory of being held upside down. And how scary that was.

And so what ended up happening was I was able to complete my instrument training and get my instrument license and now I'm flying high performance aircraft. I fly high performance, complex airplanes and I'm instrument rated and I really enjoy flying.

Interviewer: You don't go into panic?

Douglas: Uh. You know I'm real respectful of it. And I know my limits. And now I'm not so driven to have to do all that acrobatic twisting and turning business. But it's interesting too because now I've been able to do things that are fun and incorporate that. Like I went on vacation in Hawaii and they had this trampoline thing at the beach, with this harness that attached to your waste and your hips. And then you bounce on it and you can do flips and twists and stuff and they can catch you. And so I was doing double back flips and stuff and just really enjoying it. Instead of being freaked by it. So it started being fun.

Interviewer: Well, you have a lot of talent around that and a lot of experience.

Douglas: Right, yeah.

I've also had...like there's been over the course of 20 years I would get excruciating migraine headaches about once every 6 months or so. And what I finally learned is that if I let myself...usually I needed somebody to sit with me cause it was too overwhelming to do it by myself. But if I could get someone to sit with me and maybe put their hand on my shoulder so I could feel they were there I could go into the feelings and would invariably connect to a birth feeling...of pushing and pushing and straining to get out. And then having forceps clamping on my head. And the feeling I would go into when I would be having those feelings from the migraines is it felt like somebody was stabbing a knife into my brain. But it was just excruciatingly painful...and then I would black out. And then I would like I would come out of the black out and I would be like...sometimes my body would be like in a seizure. You know it would be jerking and twisting and stuff all by itself. I would

slowly return to consciousness and it was like my consciousness started noticing that I had a body and that I was there but my body was jerking and twisting and flopping around all by itself. And of course that freaked me out too when I noticed that. And then what I would do is I would go back into feeling. There was a part of me that was still... I was angry...I was just like straining...straining and pushing and angry. And then my head would be hurting like hell. And then it felt like somebody would be stabbing a knife into my brain...I mean in my brain...that's how it felt. And the pain would get so intense I would black out. And then I would start coming back to consciousness. And then my body would be flipping and twisting and jumping. And so eventually I would feel through that piece and come out and the headache would be gone.

Karlton

Interviewer: What was your experience of healing through the remembrance the pre-and perinatal?
Karlton: Well this happened during the workshop that was given by William. And he had us remember and regress to our birth. We were working in pairs. The person I was working with was palpating the energy around my head. In certain areas around my head I felt more pressure. And it began to feel like birth. And I began to feel tired and kinda zoned out. Like almost like I was going into an altered state kindof. And then I remember I laid down.

I was laying down on my left side and I don't think they were even touching me. But I had a really strong feeling of pressure on my head. Maybe they were. Maybe they were touching me around my head. But I felt my body starting to push forward. I mean I wasn't even asking it to do this. My body just started doing this by itself. And it felt like, not even so much like a memory, but more like a reenactment. Like my body was just doing something it had done before. A lot of pressure and a lot of pain. It was very hot. I had a lot of anxiety and I was very scared. And I remember feeling really stuck for a long time and not being able to breathe very well.

And what happened was after a while I was just laying there not planning on doing anything, not trying to do anything. But it was almost as if my body was doing it

by itself. My, head would like move forward like as if I was stretching my neck. My head would kind of, ah wobble left to right. I was laying on my left side. And things like my head would push forward and then like I would kinda walk my shoulders up after that. I remember that the pressure just got stronger and stronger and stronger. And you know what my head actually felt really kind of plastic. Like you know rubbery. And like it felt like it was caving in. And I can remember just feeling so strongly. I can even remember right now as I'm thinking about it. It was like there were certain vortexes of pressure. And one of them was on my left parietal, right on the rim of the top of my head where it starts to go down. And it was like the pressure was going in diagonally toward the center of my head. And it actually felt not only like my head was kinda caving in, but it even felt like my brain was getting mashed on the inside. I remember it vividly because I drew it. I drew a cross section of my skull and brain and head afterwards. Most of the pressure occurs on the left side. And as I kept moving forward. I wasn't even trying. I was like so totally into the experience that it was like guiding me, making my body do it. And um, it wasn't like a particular suggestion or anything. William got everything started but it was like this whole thing took over.

And I totally believe it was memory and reenactment of my birth. It just felt ancient. I felt really little and really helpless and scared. And um, then I started feeling pressure on my right side of my head only down farther. It's funny, as I'm talking about it I can start feeling it. And I don't remember if the person was pushing on my head or not. It didn't feel like hands, that's for sure. And then I got stuck again for a long time. And then I started feeling like the whole world was caving in on me and I didn't know which way to go. I didn't know which way to turn. I didn't know how to move. And I just gave up for a long time. But then I started feeling like I was going to die. Like I couldn't move. And I got really scared. And I felt like I had to do something. And I just started struggling like crazy. But it was all like an internal struggle because I'm quite sure I wasn't flailing around. But it felt like I would have if I could have. But I couldn't, I couldn't.

And finally what happened was my head twisted, my chin twisted to the left, toward my left shoulder. Then all these pressures changed, cause it felt like someone had taken like a belt or something and tightened it up really tight around my head and then just twisted it with my head staying still. And, I think, I almost think I might have passed out for a while. But then I remember like being, like my head was turned so that my chin was on the floor and above my shoulder. And then I moved forward and all these pressures changed again. And the way they were changing, my cranium changed. And then after that everything kind of popped and I kinda crawled forward a little bit. You know, felt some relief from the pressure.

But I felt a lot of pain. I felt really alone. Really scared. I started crying. And couldn't breathe. I had really stuffed lungs. I felt like I was going to suffocate. And my vision was really, really, really blurry. I've never experienced anything like it before. It was almost as though I was looking through Coke bottle bottoms. I felt really scared. And I thought, "What the hell have I done?" I kind of felt like, "This is really a weird thing I've just done." I also felt like, "I know I'm gonna be O.K. but I'm really scared right now." I really felt little, really helpless. And I just cried and cried and cried. Couldn't breathe. I'd freak out not being able to breathe and stop crying. Then I'd start crying again. So, I could hardly breathe the whole rest of the night. And my vision, I mean I couldn't drive home or anything. And my vision was still really bad.

And the next day. I mean I didn't know what to do. I was thinking, you know, I really messed myself up. And the next day my vision still wasn't the same. I put my glasses on and they didn't feel right. I was really pretty freaked out about it, as I remember ...but my head felt pretty good. And my body...my lungs felt really good. It was a very, very, deep, deep regression. Really deeply altered. And it seemed like it lasted forever. It probably only lasted about 40 minutes.

But I remember, oh God, my eyes weren't getting better. And that's when I went to my doctor, eye doctor. I said, "Check me out, see what's going on here." And he's like,

Optometrist: "Well what have you been doing?"
Karlton: So I told him everything I did. And he was like,
Optometrist: "Wo, that is kind of weird. Let me check you out."
Karlton: And he checked me out and checked me out. You know how they do it. Which is better, this or this? this or this? And this went on for about 15 minutes. And finally he said,
Optometrist: "Just come with me. Come over here."
Karlton: And what happened, he went into his office and he reached up over this tall bureau or hutch kinda thing. And he brought down this box and dusted it off. Opened it up. And there were all these lenses like, kinda like rings at a jewelers. And he said,
Optometrist: "Now okay, now. Close one eye and I'm gonna hand you this lens and you look out the window and see if you can read that license on that car."
Karlton: And it was snowy and the car looked like it was at the end of the parking lot. And I was like you know, "RX51237." And he said...
Optometrist: "I don't believe it! Your vision has gotten like 50% better than it was last time I saw you, 2 or 3 years ago!"
Karlton: And then he went back to his modern instruments and he gave me a new prescription and I've had that new prescription since then.
Interviewer: How long has it been?
Karlton: Oh, 12 years. No, no, no. It wasn't that long. Let's see, when was that? Probably 8 years ago.

Caroline

Interviewer: What was your experience of healing through the remembrance of the pre-and perinatal?
Caroline: I had had a real bad birth. My parents talked about it all the time. By the time I was 19, I was in tremendous pain, having trouble walking and a lot of like arthritic pain up and down my spine, affecting my neck, my head, my arms, my legs. Everything. Every part of my body was affected. I wore a full spinal back brace, from the neck to the tail bone. And I used a cane for a while. And I couldn't do household chores. My daughter who was 8 at the time had to do all my chores for me.

And so I read a book about babies remembering their

birth, I mean an article rather, in Mothering Magazine. This was about 13-14 years ago. And Dr. C. was referenced in the article. And I thought if I ever get to San Diego I'll look him up, because I felt that that ["bad birth"] was what was responsible for all my body pain. So when I moved in August of 1985 I looked Dr. C. up and we started working together. With his help using clinical hypnosis we went back into my birth, covering every aspect of it. And every time we reclaimed some sort of trauma that had happened at the time I was born, my body would respond by correcting the trauma right there as I lay on the couch... as if in confirmation of what we were doing.

And the first...one of the first things we recovered was that my heart, this was an emotional response to birth, but my heart was in a great deal of pain and had been for a very long time. And it got worse just before I began to see Dr. C.. And I asked him about it and so we went into hypnosis and what it was that my mother had wanted a boy. And...I was a girl of course. And so what came out was that I was born with the feeling of a broken heart. Because she'd wanted a boy. And we went into the feelings about this. I cried. And as I cried I felt like a great weight being lifted off my chest. And that was the physical response I had to uncovering the fact that my mother had wanted a boy instead of a girl.

And then I had at least 12 sessions with Dr. C. where I felt like I was being squished and squashed coming out of the birth canal and could not breathe. So there was a great deal of panic and a great deal of feeling of dying. And anger. The anger came from the fact that I was doing so well until my mother took this drug and when she took this drug so that she would not feel the labor I slowed down too. I was unable to move and this infuriated me. And so we went into that memory at least 10, 12 times. And again I felt a great deal of untwisting taking place in my body. A lot of freeing up.

Then there was the fear of poisoning I'd suffered all my life. I was even on Oprah Winfrey about that.
Interviewer: Oh, with Barbara?
Caroline: Yeah. I went on a very, very strict vegetarian diet for 12 years. I was always trying to purify my diet so I could free myself of all these poisons I felt were inside my body. And what happened was one day Dr. C. and I went into the fact that I'd

received transfusions immediately upon birth. And that was because I was an unexpected RH baby and the first transfusion was the wrong blood. They brought up the wrong blood from the laboratory. And they'd even started giving it to me. My body went into complete shock. And on the couch with Dr. C., I think for about 30 minutes, I was convulsing as I remembered this memory. And almost immediately they got the right blood. They realized something was wrong. When Dr. C. and I brought up this memory my fear of food went away and I went back to eating meat. I eat anything I want now. I thought I went into not eating meat because of noble longings. The purer you are the more spiritual you are type of thing. But it actually boiled down to wanting to purify my body out of fear of toxic poisoning and dying from the toxins in my food. And it stemmed from the birth.

Interviewer: Was this accomplished in one session?

Caroline: Yes, that was resolved in one session. And I was really surprised, had no idea. And then I had a session where it's really odd the way they gave me transfusions. They would cut about an inch long. I have scars all over my body. Three on each foot and then I had a session where...it's really odd the way they gave me transfusions. They would cut about an inch long. I have scars all over my body. Three on each foot and one on each hand and several on my head from the transfusions they were giving me. And they would hold the...they would cut me without anesthetic. And the cut was about an inch long, so that if it was on my hand it would cover my whole hand. And then they would put a wooden splint there. And they would be giving me blood through...I don't know...I imagine the standard tube-type of blood. But when Dr. C. put me under for that I felt the pain of the knife. I could actually feel the pain as though I was there having surgery without the anesthetic. And what I did to...because this was done so many times on my body...was to learn at that point in my life to leave my body. It was very easy for me to leave my body from that point on. Because I was being cut quite a bit.

Interviewer: And they didn't realize you could feel it?

Caroline: Oh no, and they didn't realize and they still think babies don't feel it. And they certainly do. It was horrible. They cut my feet first. When I started feeling the second cut that's when I started

feeling...I said, “Oh gee I’m feeling real goofy. I don’t feel pain anymore. I feel like I’m light and I’m floating up.” You know if you said, “Well are you leaving your body because of the pain?” And that’s what I did. I started doing that from that point on to handle the pain that I was subjected to in my life at my birth and from that point on to handle the pain that I was subjected to in my life at my birth and from abuse when I was a child.
Interviewer: You were abused?
Caroline: Yes, sexually and physically abused. My father sexually abused me, but at that point in time I was able to leave my body because I had done it so often as a baby.
Interviewer: Do you still do it?
Caroline: Um yes, I can still do it. Yeah I can do it. I don’t really feel too much. I still don’t. Then there was my life-long need to have a window open. Some of that came from just birth and just having the panic of feeling you can't breathe. As you're coming out you're being squeezed and feeling like you're being suffocated. But I also had a pre-birth memory where my father was having sex with my mother shortly before I was born. And there was a pressure that was being applied there. There was no concern for my welfare. And it was probably what you would call "rough sex" And there was pressure applied on me. And I felt cut off from my oxygen and I was panicked inside the womb. And the fear of not being able to breathe and having to have windows open left after reliving that memory. And I used to not be able to allow anyone to spray anything around me, whether it was perfume, hair spray, anything like that. I'd be in a tremendous state of panic, feeling "Oh my God, I won't be able to breath!" But that disappeared also.

Rachel

Interviewer: What was your experience of healing through the remembrance of the pre-and perinatal?
Rachel: Well I was at STAR at the time which is a 17 day intensive workshop and I was working with Barbara. I basically didn't believe... I mean it just sounded too bizarre to me that there could be some sort of "rebirthing." The whole thing just sounded very bizarre to me, but...I thought, "What the heck.

Nothing ventured, nothing gained." And Barbara... I was in a quiet place with Barbara and my reader, Kiara, and Barbara started doing the guided visualization, the guided imagery and ... I felt very disconnected from, until the point... I felt very disconnected from everything until the point where Barbara asked me to remember or asked what it felt like at the moment of my conception. And I immediately felt rage. I guess my face got all red. And, I felt that I had been conceived in a rape. Good ol' marital rape. Happens a lot more than people want to talk about. It was a marriage of convenience for my mom. unfortunately my poor father was totally head over heals in love with the woman. Nothin' sadder than that. And I thought that both my parents were very angry. And I was very angry. And I didn't want to be there. I didn't want to be there. At the same time, I felt like I was swimming around. I didn't feel like there was anything I could attach to. I didn't feel like there was anything, you know, warm or nurturing about the experience at all. And I felt like I was swimming around in a sewer.

There was also at the same time, I had gotten extremely ill with asthma, which I had had my entire life. I was really sick enough that I probably should have been hospitalized. But I couldn't do the whole med thing anymore. At that point I think I was on 14 different meds. I was on a full battery of everything. From antibiotics to broncodialators to steroids to three different kinds of inhalers. And I was just a mess. And during this whole thing I was wheezing and coughing and getting worse as this thing [the session] went on. And I was really afraid that I was going to get into a really serious you know kind of grand mal asthma attack. But I also didn't feel like... I felt trapped. I didn't feel like I had an option. I mean I felt like I was trapped in this experience. And that's just the way it was, actually. I didn't really think about it in any objective sense that I could stop the experience or you know, quit in any fashion. So the regression continued. And I can't remember exactly how it progressed but I remember that it was harder and harder to breathe and I was feeling more and more trapped. And I was feeling crushed. And that... that...like I was going to die. I really felt like I

was going to die. And I remember starting to yell out or scream out, "No!" And at some point... And I was coughing and couldn't breathe. It seemed to be getting worse. And at some point I started screaming. I just started howling. And it was like I took the first deep breath of my life. And it was, it was... my asthma broke and I took this deep breath that seemed to extend down to my toes. And I felt like I was breathing, that I had taken the first breath, the first deep clean breath that I had taken in my entire life. And when my asthma broke I knew at that moment, and I don't know why I knew it or how I knew it but I knew at that moment that I was never going to have asthma again the way I'd had it. That it was gone. And all the wheezing stopped and all the coughing stopped and my lungs were clear. And I could breathe again.

I was still trapped in the middle of this birth regression thing and trapped, you know stuck...stuck in this room situation and still felt like I was trapped in a sewer. And it was still hard to breathe. But it wasn't the same sort of choking...where I felt like I was going to die. It was very different. I could breathe. I was still stuck but I could breathe. And I knew that the whole asthma thing was gone.

And, so we kept going with the birth regression, and Kiara and Barbara were putting pillows on me and applying pressure and I was feeling more and more trapped. And I started just screaming out again, "No!" And I remember at one point I rolled over somehow, on my right shoulder and my neck, and I couldn't breathe. I was totally, I felt totally crushed and totally trapped. And I really, I just went ballistic. I really lost it at that point. I'd been hysterical before but it was a new level of hysteria. And at that point Barbara asked me if I wanted to yell, "Pickle!" to stop the birth regression which I said, "Yes I did." And we stopped at that point.

And at that point I really was feeling like I was crushed. And I also had the knowledge that if I didn't stay huge that I was going to, that I was going to die. If I didn't stay huge I was going to be crushed. That I had to exert pressure against my environment to stay, to not be crushed...by being big. Which I am.[laughs] That's one of the things I'm working on in the next few years of my life.

During the birth regression I also felt like I was getting beat up. Like I was being crushed and pummeled and just beat up. You know, and I hurt all over. That was the first birth regression and then their was a second birth regression. And the second birth regression was done with Maureen Wolf. It was radically different. Basically what I felt in that one was that I was just exhausted and that there was nobody there to help me get out but me. And that I sort of crawled my way out of the womb and uh I was just there. I was really depressed and sad and underneath, angry. It was awful. The other thing about Maureen W., the Maureen W. regression was that I also had tremendous difficulty breathing. So that was part of that too. I mean I, when I was in the little two sheet bag she put us in, um, I felt like I was suffocating again. And there was nothing in between me and the air. I mean just a sheet, you know. But I still couldn't breathe.

Amy

Interviewer: What was your experience of healing through the remembrance of the pre-and perinatal?
Amy: I had been in a relationship with a woman and we had...I'm adopted. So it was after I'd found my birth parents. It must have been about 1986 that I got involved with her. And she was really the first person I had opened my heart up to. She'd been a friend of mine and we then became lovers and she was really a person that I felt unconditional love from. I think really that came from my experience of having met my birth grandparents, in particular on my father's side.
Interviewer: How's that?
Amy: Because when I met them I felt....exhilarated. You know these people that I wanted to connect to my entire life and they accepted me. And it was really a wonderful experience. So I really opened up in a way that I never had been before. And I've heard many adoptees say that. For example, a couple of my friends never had orgasms until the met their birth parents. There's something that energetically happens.

So...I had met my mother but I didn't really know much about her. She pretty much rejected me right when I met her. She didn't wanna...she couldn't handle it. And then I met my birth father in 1986. And then I

became involved with my friend...I guess it was about 1987.
Interviewer: How old were you?
Amy: Well lets see, I was born in 1960 so you can figure it out. I'm not good at math or remembering that kind of stuff.

So anyway, we were involved for about 2 years. And during this time...at the end of our relationship I still just really...I mean I had this experience deeply caring for someone that I'd never had before. I was very attached to her. And she told me at this point in our relationship that she couldn't be partners with me any more, and that she had to be by herself. And I knew her history and that was going from one person to another. And I didn't understand that but I loved her, or so I thought. So I said, "Well, whatever it is you need to do...because I really love you. And that's painful to me but...okay." So we broke up. And it was really excruciating for me. But I also felt kind of like I was on hold in this certain way. Like I didn't understand why we broke up. There didn't seem to be any reason for it. Nine months later I found out that she had been having an affair. And I was really devastated by this.

And so anyway after I found out about her affair I would be in bed at night and I would wake up in the middle of the night, about one or 1 or 1:30 or so in the morning, in excruciating pain. And I would be curled up in the fetal position. And I was in so much pain I literally thought that I was going to die.
Interviewer: Was this emotional pain?
Amy: Yeah, it was definitely emotional pain. I mean I...I experienced some physical pain in the sense that I wasn't really willing to change my position. I just found myself in this position and there wasn't really any way I could get out of it, you know? And it was just really painful.

And I don't know what happened to me but somehow... I asked myself this question that seemed to really open everything up for me. Why was I in the fetal position in such agony? And I stayed in that position and stayed with the pain until I realized that absolutely everybody I'd ever been involved with had had an affair. And I had been very unconscious about this, you know. You would think that if everyone you'd ever been involved with had an affair you'd remember. But I

was very unconscious about it. I just was in the pain or whatever of the break-up. But this time I really got it. It was like, "Oh my God!" You know, I was with Jimmy Arigoni in the second grade. And he went out...you know, he kissed so and so. It was like that. And so the question I somehow asked myself was, "What does this have to do with me?" Like, "Why? Why am I always picking people, basically, that are lying to me?" So basically, I just kept staying with that until I realized that I was replaying my birth parents' story.

What had happened before I was conceived was that my father who was in the Navy at the time was engaged to be married to his childhood sweetheart. And when he was stationed in San Diego he had had this affair with my mother. For him it was an affair. And for my mother it was a relationship. And she was wanting to be married. And she was totally thrilled...That's where she was coming from. And he never told her that he was actually engaged to be married to somebody else.

So, at one point he had to fly back home to Connecticut and...The story that I heard from my father later was that during that time when he'd flown home to Connecticut , she called him there and told him that she was pregnant. And he told her that...well, he was engaged to be married. So I just felt like I was replaying my whole family history.

And so basically what happened was that during the time of this pain I just kept opening up to the feelings of being abandoned and being betrayed that I think both my mother felt and I felt when I was in utero. And that actually it was probably impossible for me to really feel those feelings at that time because they were so intense. I mean I really did think I was going to die. And my mother actually did try to abort me several times. So you know it wasn't just my imagination. I'm trying to remember. I think it was actually around July...September that I found out about my girlfriend's affair and I was born in December. So, considering I was conceived in April I would have been 6 months old in utero. And of course I wasn't thinking about any of that at that point. I'm just going back to it now.

Interviewer: You weren't doing birth regression work at the time of your break up?

Amy: Oh no, not at all.

Interviewer: Did you remember your mother trying to abort you?
Amy: Well, yeah. That's another story, though. I mean I literally during this time when I found out my partner had had an affair, I really thought I was going to die. I couldn't breathe. It really brought back I think both my abortion memories and memories of being conceived while my birth parents were having an affair. After they found out that my mom was pregnant they did try and get an abortion. She was living in San Diego and they went down to Mexico. And she wrote a letter that I still have in my possession to the doctor that delivered me requesting an abortion. And he wouldn't do that but he said, "I know of someone who will adopt your baby." So basically I was just reliving the whole experience. And there was...I think what happened was that I had to...it was sort of like people had been knocking on my door saying, "Amy wake up to this fact. You've been betrayed and abandoned and almost killed. Feel those feelings!" You know I had plenty of opportunity to do that while I was growing up but I wasn't able to. Maybe you weren't ready. Yeah.

And so at this time in my life I had a really incredible support group. And I knew many people that I could call at 1:30 in the morning...and talk about it. So I would say the healing really came from experiencing the original pain of that.
Interviewer: The original pain of ...?
Amy: Of the abandonment and the pain of the affair.
Interviewer: While you were in utero?
Amy: Right. Because I feel myself...I feel that I was feeling both my feelings and my mother's feelings. And...I mean the result of that has been that I haven't been in a relationship where that's been an issue. Of having an affair.
Interviewer: So you mended that relationship pattern?
Amy: Yeah, yeah. And actually what happened, you know...it wasn't like, "Oh magic presto now I never have to deal with this again. What really happened was actually I went through...there was a current person I was involved with. And she wasn't really done with her other relationship and she kept kind of wavering about it. And I said, "Okay not interested." It was very easy for me to separate and to know that...I was conscious enough to say, "Okay this is the pattern."

So that was the first thing that happened after that experience.
Interviewer: So being aware of that pattern, you were no longer as vulnerable to the attraction to someone who might betray you?
Amy: Yeah, uh huh. I was still attracted to the person but I was very clear that this was not healthy for me. And it was very easy to not be in the relationship with her.

And then the second thing that happened is that my current partner who I've been involved with for...I think it's been 6 or 7 years. We'd be sort of dating. And the more committed we became the more she started getting this thought about this other woman. She might need to go out with her. And she talked with me about this. And I told her, I said, "Well if you do that I'm not at all interested in having a relationship with you. And I'm very clear on that. And that's how it is." So we worked through that together. And it was great. And she would just bring up her feelings and I would say it very clear, "Nope, not interested." And it hasn't been an issue. She got to the bottom of what that was about for her. So it just hasn't been an issue in our relationship at all. That's great. Good work." Yeah, so that's my story. That story anyway.
Interviewer: You're very brave to do all that work virtually on your own and to dig into those difficult feelings.
Amy: There's another part to it which is pretty interesting. My father's daughter after me was married to this guy. And he ended up having an affair with a woman named Rose, which is my mother's name. And they broke up over that. So...and my father is still kind of playing out the whole affair thing.
Interviewer: You mean he's having an affair?
Amy: Uh huh, yeah. So it was clear that it was something that is a family pattern. I mean, it was just really wild to me when my sister...you know her husband had an affair with somebody named Rose.
Interviewer: That's really wild! She started carrying out the tradition.
Amy: Yeah and it had begun way before she was born.

Jesse

Interviewer: What was your experience of healing through the remembrance of the pre-and perinatal?
Jesse: Well, just to let you know this guy named Max started a class. He was over to ask me to go to a class he was giving, where he did a process called "relaxed focused attention" (RFA). In an RFA you go back to an experience in your life that was causing trauma in your present day. And I know several other people who have had similar experiences and these are not guided by him in the sense that he tells you where to go or what to do, what to see, what to think. Its just you go through the experience. So anyway, so basically I had a pain in my right side that I'd had for 3 months and I had been taking Vicodin [a prescription pain medication]. They thought it was something gone wrong with my kidney. But there was just no indication of any medical problem that they could see after being in the hospital for a couple of days. Doing every kind of test they could think of, couldn't find anything. Max shows up to invite me to this class he gives and like I said I am wary is the thing of it. I asked him if he was there to heal me. He's just that kind of guy. And he asked me what was the matter. So I told him what was wrong. And he asked if I really wanted to know. And I said "Yeah."

So, basically he just got me into a relaxed state of being and started asking me some questions. And he did muscle testing to see if this was the place where the trauma occurred. And he took me back. I'm not a believer in this stuff. Never experienced anything metaphysical so its not like I had a frame of reference to know what was going on. Just following him out of desperation. Well, I trusted him, so, it was just kinda weird. I had talked to him several times and known him for 6 or 7 months or even more maybe.

[So he went through the early years of my life and that wasn't the place, that wasn't the place, that wasn't the place until my current age. Then he just said to me, "Imagine that you're back in the womb...Is this an incident that occurred in the first trimester of pregnancy?" And the answer was "No," the second trimester (?) "no," and

we got to the third and the answer was "Yes." He said, "Tell me what's just happened." And I said, "The picture that I saw," I said, "I don't want to say it. You know, it just couldn't be true." It took a little coaxing from him to actually get me to say the words. And the second he said "The 3rd trimester of pregnancy?," I had pain on my whole right side. My whole right side went to pain. And he said, "Tell me what's just happened." And I didn't want to say it, cause I think I'm making this up, you know? And he said, "What's happened?" So I said, "Well my dad has just hit my mother in the stomach." And you can see why I didn't want to say that. So he just went through an exercise of why does your dad do it? What was going on? Were they arguing? My mom was threatening to leave. I was just rehearsing this whole story of stuff I could have had no knowledge about. He said, "Why does your dad hit you?" You know, he's just angry and basically he just had deep anger. I can't remember all the specifics anymore. He just had deep anger and she was going to go home to her mother, which my mother has done all her life. Things get bad she'd go home to her mother. And my mother's perspective, she wasn't going to take it any more. He was controlling her and I could really sense all that.]

Then he [Max] did something really interesting. He asked me to just go around and step behind your dad and have the experience through his eyes. So I'd come into his mind and saw it through his eyes. And I just kind of did what he asked me to do. And all of a sudden, "Where did he get this anger that he has, this mistrust of the world? And he used force to get his way." And I said well, from his dad. His stance was from being moved around when he was a kid, and never having a home. And I started rehearsing his story of where all this anger came from and then. Where did he get it? From, his dad. So I rehearsed a story about his dad which I don't remember what it was. I don't remember his story. And then I went back to his dad's dad, my great-grandfather. I told a story about how they were living on a farm. He was out in the farm yard and some of the horses stampede and he gets hurt and he's calling for help and nobody comes. And so he made a decision. That you can't trust life kind of a thing. Nobody's there to help you. You're on your own.

Then I went back in my mother's mind and did the same

thing. And, my mother's story was that she had kinda gone without and they come from a poor family and had that experience. I skipped my mother's mother and went to my great grandmother after that . I rehearsed this whole story about how she came from a pretty wealthy family, sophisticated, and married beneath the family. And the man she married finally had no get-up and go and she was the driver of the family and she had resolved in her life just to accept the, you know, the bad decision she'd made and carried a lot of anger and resentment and frustration about her husband and the consequences of her life. I mean, just different stories around that. I don't remember them all. It's been a couple of years. I'd met her when I was about 3 year old boy. I can kind of see pictures of her in my mind. I can kinda remember her house. And him also. And there're still things I didn't know, I'm just telling these stories. [Some of it I just started blubbering, just an incredible release of energy, just started crying, crying uncontrollably.]

Then he asked me to...first of all, from my great grandfather on my dad's side he just asked me to relive the experience only when I call out, just picture his parents coming and saving him. You know, they actually came. You know? And I started crying then that they did care for me. That they did love me, kind of a thing. And on my great grandmother on my mother's side he asked me to just to acknowledge that she really did suffer. That she really did go without. She really did, basically, give her life away to a lifestyle of living in a poor situation and staying with the man she married even though she was unhappy for most of her life about it. And to look forward, ...have her look forward and see me. And see what the result of that sacrifice on her part was. You know the man that I'd become and the blessing that she'd created because of that. And I cried at that one.

But I had an interesting experience. Once I saw even beyond her like all these...my predecessors from generations back just like cheering for me. Like, "somebody had got it." Somebody had got it finally, you know? What they got, I don't know. [laughs] It was like somehow my life had bearing on whatever their existence is now. I was incredibly emotional about them looking down and seeing. It wasn't down. It was like across from me just all lined up, cheering and

excited. Somebody had finally got it! Somebody broke the chain, basically.

[And then we came back from...to the present, and saw that the illness, my back pain, was really associated with that (the 3rd trimester violence). He acknowledged that and that I could now release that energy. And I did. And within a few hours the pain was mostly gone. And the next day totally gone never to return.]

Just to let you know one thing that I did is that after a period of time I kind of recounted this with my mother. I wanted to know if any of these events really had taken place. And I had about 8-10 specific things that I recounted, like being hit, information about my dad and my great grandmother and her marrying beneath her and all. I related to her all of those things to see if, am I making this up or what? And she validated about 8 of the 10 things including that my dad had slugged her late in her pregnancy with me.

[*Much of Jesse's interview veered from the experience in question to the relating of his perception of others' experience unrelated to pre- and perinatal phenomenon. As such, only those portions of the interview the researcher felt were related to the current study have been included in the data. They are bracketed.]

APPENDIX J

Themes with Summaries

Marisa

Themes

Anguished Physical, Emotional, and Feeling States
A Perception of Mother's and Others' Reality
Relief or Healing
Consciousness as Separate from the Body
The Light of Healing, Compassion, and Love
Loving and Losing Her Twin

Summary

Marisa is a woman who lives with her partner in San

Francisco. For about 20 years she was a practicing attorney while raising two children. Now she counsels children and adults in regular and art-based psychotherapy. She attended a 3 week retreat in the Bay Area with a focus on birth regression. Her remembrance of the pre- and perinatal is vivid and complete. It goes like this.

Marisa described having a spiritual experience. She found herself as a soul without a body preparing to come to earth, "hanging out in the universe. ...in a little egg of light." Her purpose in coming to earth was to bring the light "of healing, compassion, and love" to a few people.

Her conception was a disappointment, though. "I immediately had a feeling that it was the wrong place, wrong people, and the wrong time." Her parents were drunk. "The egg and sperm were together in a nauseating, smelly, alcohol soaked womb. My parents had come together by accident, not out of desire and intention."

Working down the fallopian tube in the dark, Marisa felt "terrified about the ride. “Her description of the womb was that it was full of black, tarry stuff, "goo-like gloppiness, " ..." like grasses in the sea that are polluted by an oil spill." "It was almost impossible to see and survive because it smelled and tasted bad." Survive she did, though. "It was very difficult to do." Repeatedly, she attempted attachment to the wall of the uterus which was made impermeable by "all the tar and gunk." Her mother was a heavy smoker.

Marisa became aware of another being. She had found her twin. But the other being was "weaker and more scared than I was." Trying to come to the aid of her ailing twin, Marisa did without to give to her. In a "totally heartbreaking moment," however, she watched this being die and fall away. It was "an enormous, crushing loss."

While she grew, Marisa became aware that her mother did not want her. She did not want to be a mother at all. She had a 9 month old baby already, and she did not want him. Her mother was even thinking of suicide, rather than carrying Marisa. Then later in her life, Marisa remembers reenacting this memory by attempting suicide herself when her daughter was 3 years old. She almost died.

Her father was emotionally, "dead to his feelings." Underneath the deadness was fear. Her mother spent the rest of her pregnancy with Marisa on the couch, "drinking and smoking." She felt that her mother was "trying to kill me in a passive way." A maid took care of her brother. Marisa looked forward to knowing him. He was her only positive light. Marisa felt very sad, and unwanted. Even then she tried to be quiet and good so maybe her mother would love her.

At 2 1/2 months of gestational age, Marisa elected to be born. She decided that the uterine environment she was living in was no longer tolerable, and "gathered all my energy to support the feeling that I had to get out of there." This is a feeling she has carried with her the whole of her life. Her mother wanted nothing to do with the birth and arranged for the doctor to "knock her out." So Marisa got no help.

The birth was really difficult, because she was "poisoned and toxic" from the start." But she continued to push. "A life and death struggle gives a person a certain amount of strength. Even though my mother was drugged, I was drugged, and it was hopeless, I was making progress. The next thing I remember is feeling a cold, metal instrument grab me around the head and pull." She was enraged. How dare the doctor "rip off her triumph." She felt that she had done all the work and then wasn't allowed to be born.

Marisa felt so alone after the birth, she began to cry. No one held her or cared whether she was there or not. She psychically made a pact with her mother to die later if she would just hold her. A nurse picked her up, only to leave her alone in the nursery. She made a similar bargain with her father whom she saw standing at the nursery window with tears in his eyes. Marisa felt some support and validation from a nurse whom she perceived to have a judgment against her mother for not caring for her.

Douglas

Themes

Anguished Emotional, Physical, and Feeling States
A Perception of Mother’s and Others’ Reality
Relief or Healing

Consciousness as Separate from the Body

Summary

Douglas is a 50 year old man with a long and full history of resolving birth related trauma for himself, and with others. He currently operates private psychotherapy practices in Santa Rosa and Los Angeles, California with a specialties in birth regression for babies, children, and adults, and is the former president of the Los Angeles chapter of the California Association of Marriage and Family Therapists (CAMFT). Douglas became interested in pre-and perinatal psychology as a matter of necessity as he was personally faced with a life-threatening, suicidal depression. This is his story.

While holding a position as a psychotherapist in a mental hospital, Douglas found himself challenged with a young, male patient, suffering from a first-time, psychotic break. For 3 months he did everything he could think of to make contact with the young man, including, "grabbing him, talking to him, wrestling with him, bumping him, singing to him..." Nothing worked. The patient was placed in a half-way house for the chronically mentally ill.

Though Douglas had faced his own low-grade depressions frequently in his life, the 2 year depression that was triggered by his encounter with the psychotic patient was by no means low-grade. He became despondent, and wished for his own death. He didn't and couldn't work. In therapy 3 times a week, Douglas was "crying all the time." He took Prozac. He lived on his good credit.

Fortunately for Douglas, he found a retreat center that dealt mainly with therapists in mental/emotional crises. The center was run by a world-famous birth regressionist, and staffed by therapists specializing in pre-and perinatal issues. Says Douglas, "While I was there I recovered the memory of almost dying at my birth and remembering how excruciating it was."

He described his mother as, "...a short, stocky, muscular woman," who was, "terrified," and who "did crush a baby to death," referring to his brother before him. “So she just clamped down and just crushed the babies." He had begun to discover the roots of his depression, and the origins of his feelings of

alienation, for as he states, "...I really got in touch with how excruciating it was to be born, and how isolated and lonely I felt having a mother who couldn't connect to me."

Memories of the anesthesia used during his birth surfaced as he became unable to stay awake in certain circumstances. "I would literally go unconscious." Painful memories of the use of forceps came back, along with the trauma of not being allowed to bond with his mother. A very sad memory for Douglas was when he recalled being in utero and having the realization that his mother did not want him. "...she was still in mourning for the loss of her first child... So she was full of grief and I was marinating, as I was cellularly growing, in her grief."

Learning to allow himself time each day to feel the grief and sadness that underlay his depression was a key for healing. "I would wake up every morning wanting to be dead. And if I gave myself the time and space to have my feelings and grieve, from 10 minutes to 30 minutes, I would be fine and could go on with my day... But if I didn't, I would be depressed the whole day." This grief process lasted from a year to a year and a half. Then Douglas felt as though he had emptied "that primal core of pain" and he didn't need to grieve so much. And now, he says, "...depression is hardly with me."

Years later, Douglas encountered opportunities to resolve more of his birth trauma. For example, while undergoing a course of primal therapy, he suffered a blackout during his morning shower. A practiced expert at recognizing probable birth related trauma, Douglas wasted no time in establishing a primal setting at home. He created a "nest" out of blankets and towels and invited a primal therapist friend over to help him. He recreated the blackout by showering in very hot water. By catching himself just before he lost consciousness, but during the time when his vision blackened, he could exit the tub and enter the "nest." Birth feelings arose quickly as a result. According to Douglas, "It was the feeling of being born and having my head crushed and having so much pressure on my entire body from my mother just clamping down that I would fight and fight, struggle and struggle, and try to push, and I would be in a rage trying to get out

'cause she wasn't helping me. And with the intense pressure along with the intense rage I was having, I would black out. And so I went into those feelings there on the bathroom floor of just like raging and blacking out, and then raging and then blacking out, and then crying and just cycling through those feelings." Until the raging and the crying went away. "It was really scary at first but there was something that attracted me to it at the same time. Something about it seemed familiar." More than 20 years have elapsed since Douglas was bothered by blackouts.

As a child and young adult, Douglas ranked nationally as a gymnast. He worked hard at it, 6 days a week. He was in very good form. But he clearly had a problem with tumbling, flipping, and twisting. He describes going into "immediate terror" whenever he let go of the apparatus and started to twist or tumble. He remembers many times trying to do a "layout flyway" off the high bar, and losing his orientation. He would rotate one and a half times instead of once and land on his head. Consequently, he ended his gymnastics career in college. However, he never gave up the desire to "work through" this obsession.

After a brief return to gymnastics, preparing to compete in the senior Olympics, Douglas broke a toe and ended this career for good. But he wasn't done trying to resolve his issues with tumbling and twisting. He decided to learn to fly aerobatic gliders, used often for flipping and twisting. Douglas decided to learn to fly regular planes first, however, because there was no accessible glider port.

He describes himself as a "white knuckle" pilot at that point. He took 4 years to learn what is normally a 3-4 month course. "The whole thing really scared me a lot," said Douglas. After graduation, though, he signed up for "instrument training" which would prepare him to fly on instrumentation alone. For example, in a storm, with zero visibility, the pilot can successfully maneuver the machine, if he is instrument proficient.

Douglas wasn't prepared for his reaction of "immediate terror" when, the instructor placed a hood over Douglas' face, flew the plane into an unusual attitude, and said, "Okay it's your plane. Make fly straight and level." "I knew I was going to die," Douglas told me. He even lost awareness of the

instructor's continued presence. But later that night, about 2 or 3 a.m., he awoke suddenly from a deep sleep. "It was like a nightmare except that there were no images...just pure terror." While breathing into those feelings of terror, he began to shake and to cry. "Immediately, this image of my father popped into my mind of him grabbing me and throwing me across the room..." So he cried and shook and felt the difficult feelings, afterwards experiencing a "tremendous sense of relief."

Douglas kept on with the instrument training. He would go up with the instructor, feel the plane go into unusual attitudes, and then go home at night to feel the feelings of panic and terror that arose as a result. One night he retrieved a memory of his birth, of "...being held upside down and having that feeling of vertigo...of being held upside down and spanked because I wasn't breathing."

Douglas completed the instrument training, and flies high performance aircraft with confidence. He no longer feels like a "white knuckle" pilot. Also, his drive to conquer tumbling and twisting has been sated. Using trampolines and aerobatic aircraft, he has been able to enjoy flipping and twisting in the air with pleasure, now, instead of panic.

The last pre-and perinatal experience Douglas told about was when he cured himself of migraine headaches. They seemed to occur about once every 6 months. He would have someone sit with him, when they did, and put their hand on his shoulder. Then he could allow himself to go into the birth feelings underlying the headache. "...it felt like somebody was stabbing a knife into my brain. ...it was just excruciatingly painful...and then I would black out. And then I would come out of the blackout and my body would be like in a seizure. I would slowly return to consciousness and it was like my consciousness started noticing that I had a body and that I was there but my body was jerking and twisting and flopping around all by itself." After a series of these experiences, Douglas has been migraine-free for over 5 years.

Karlton

Themes

Anguished Emotional, Physical, and Feeling States
Relief and Healing
Consciousness as Separate from the Body
Feeling Overtaken or Trapped by the Experience Itself

Summary

Karlton lives and works in Denver, Colorado. The pre-and perinatal work he has done for his own growth has led him to professionally assisting others with the resolution of issues of a similar nature. Karlton came to my attention as a referral from a Bay area expert in pre-and perinatal psychology. Here is his story.

At a workshop focused on birth regression, Karlton allowed a partner, who had learned specific birth stimulating techniques, to apply pressure to parts of his head. This, along with workshop content, had the affect of helping him to experience somatic memory. As Karlton stated, "I began to feel tired and zoned out. It began to feel like my birth." Feelings such as, fear, anxiety, excess heat, intense head pressure, and pain arose, as the experience appeared to progress on its own.

Seemingly without volition, Karlton's body began to move on its own. From a fetal position, he felt his head move forward as if he were stretching his neck, and then it would "wobble, left to right." He found himself walking his shoulders up after his head pushed forward on its own. The pressure seemed to get stronger and stronger, although his partner was not increasing it.

Karlton's bodily memory of this experience was so vivid that he would start to feel the feelings again as he told me his story. His head felt stretchy, "like plastic." It felt like it was, "caving in." "It felt like someone had taken a belt or something and tightened it up really tight around my head, and then just twisted it with my head staying still." He described feeling, "little, and helpless, and scared" as the experience drew him deeper and deeper into himself. He felt like he was all alone. Karlton strongly believes that the experience was a, " very, very, deep, deep regression" and the reenactment of his birth. His body knew what to do on its own. "It felt ancient." The experience took over without his or

anyone's direction. At one point he felt as though he would die. At another, he felt like he had lost consciousness.

After feeling trapped in this place for what seemed like "forever," something finally changed and he felt some relief from the pressure. But he was still in a lot of pain. He "cried and cried," "struggled for breath," and "cried some more." He was still really scared and felt like he would suffocate. Then he noticed that his vision was, "really, really, really blurry." He couldn't breathe. He felt, "little and helpless." He felt, "trapped," "crushed," in an agony of "pain" and "pressure," and now, he couldn't see. "What the hell have I done?" he couldn't help but wonder.

The regression lasted only 40 minutes, but it could have been "forever." After the session Karlton still couldn't see, or breathe very well. Neither could he drive home that night. The following couple of days found him frightened that "...I really messed myself up." But his head, his body, and his lungs began to feel renewed.

A trip to the optometrist helped to clear things up. According to his doctor, Karlton had managed to improve his vision by 1/2 diopter in both eyes since his last exam, 2 or 3 years prior. It has been over 8 years since the regression, and Karlton has not had to change his improved prescription. Although he has done many regressions since, he remembers this one as perhaps the deepest and most intense.

Caroline

Themes

Anguished Emotional, Physical, and Feeling States
The Perception of Mother's or Others' Reality
Relief or Healing
Consciousness as Separate From the Body

Summary

Caroline is an author who lives in San Diego. She always knew that she had had a traumatic birth because her parents talked about it while she was growing up. As a child and young adult Caroline suffered

physically and emotionally. She was in tremendous pain. She had trouble walking due to the arthritis that ran up and down her spine. She wore a full spinal back brace, from the neck to the tail bone. Pain resonated throughout her body. She was also beaten and sexually abused.

One day while reading an article in Mothering Magazine about birth regression through hypnosis, Caroline thought that if she ever got to San Diego she would look up the hypnotist. She felt that the “bad birth” her parents had talked about was responsible for all her bodily pain. Dr. C. hypnotized Caroline repeatedly. He regressed her to every aspect of her birth experience. Each trauma that was revealed under hypnosis rendered tangible healing in her body at the same time. They began with a heart trauma. Caroline had suffered chest pain for a long time. Under hypnosis she remembered feeling heartbroken at her birth. It seems she could sense her mother's disappointment with her for being a girl, instead of the boy she had hoped for. She cried as she remembered the pain of being a "disappointment" to her mother. But, as she cried, she felt "a great weight being lifted off of her chest."

Twelve sessions of hypnosis were necessary to complete the regressions of Caroline's delivery. These sessions were complete with the feeling of being "squashed" as she came through the vaginal canal. Panic, suffocation, anger, and a sense of impending death were also a part of the experience. She became especially enraged as she remembered the administration of anesthetic to her mother, which had the unfortunate affect of slowing her progress. As each of these sessions progressed, she felt a "freeing up" and an "untwisting" of her arthritic condition. A fear of poisoning had plagued Caroline her whole life. For 12 years she was a very strict vegetarian as she attempted to purify her body, and protect herself from the suspected poisoning. The roots of this condition became apparent as Dr. C. regressed her to the transfusion she had endured shortly after birth. Caroline was an unexpected Rh.baby. Worse than that, the medical staff had transfused her with the wrong type of blood. Her body went into shock. Under hypnosis, she convulsed for 30 minutes as she recovered this memory. As Caroline tells it, the staff

almost immediately procured the right type of blood. After this experience she feels safe enough to eat anything she wants, including meat. Worse than having received the wrong blood, was the manner in which she had been transfused. Having been born at that time in medical history when physicians believed that babies did not have the capacity to feel pain, Caroline endured surgery without benefit of anesthesia. She has scars all over her body, three on each foot, one on each hand, and several on her head from the transfusions. She transfusions. She was cut without anesthesia. As a result, she remembers learning to "leave her body" as the cutting took place. Fortunately or not, Caroline never forgot how to leave her body. Doing it became a tool for self-defense throughout life. She had done it so often as a baby, that as her father sexually abused her, and her parents physically abused her, it was second nature. According to Caroline, "I still do it. I don't really feel much."

The last phobia to resolve concerned Caroline' life-long fear of being smothered or suffocated (pnigophobia). She always had to have a window left open, and could not endure having anything sprayed near her. When the windows were closed or anything was sprayed around her, she suffered a "tremendous state of panic." She felt she would suffocate. Under hypnosis, she had a pre-birth memory of her parents having sexual relations. She suspects that it may have been "rough sex." The memory came with feelings of intense pressure, suffocation , and panic. There was no concern for her welfare. But reliving it freed her from the phobia.

Rachel

Themes

Anguished Emotional, Physical, and Feeling States
A Perception of Mother’s or Others’ Reality
Relief or Healing
Feeling Overtaken or Trapped by the Experience Itself

Summary

Rachel came to remember her birth as a "last chance"

attempt at healing her life-long condition of asthma. She gave no real credence to the idea of birth remembrance, but decided, "Nothing ventured, nothing gained." She signed up to participate in a 3 week retreat with a famous, Bay Area birth regressionist. That's when her belief system received a lasting jolt.

Her case of asthma was severe. At the time of the workshop she was on a full battery of medications, "...from antibiotics to broncodialators to steroids to three different types of inhalers." She believes she probably was sick enough to warrant being in the hospital. She actually feared going into a grand mal asthma attack. But she was fed up with "whole med thing."

The regression started out quietly. The regressionist led Rachel in a guided visualization. Then she asked her what it felt like at the moment of her conception. Rachel became consumed with rage. She felt her face become very red. She suddenly realized she had been conceived in a rape. She felt very angry. She felt her parents' anger, as well.

During the whole experience she was "...wheezing and coughing and getting worse." She did not want to be there. At the same time, she had the sense of "swimming around in a sewer." She felt trapped. She felt trapped in the room, and trapped in the experience. It seemed to have a life of its own. Rachel felt no power to stop or alter the regression in any way.

As things progressed, it was harder and harder to breathe. She felt crushed. She felt more and more trapped. She felt like she was going to die. There was more coughing and more feelings of suffocation. Everything seemed to be getting worse. She began to scream and to howl.

Suddenly, she felt like she was taking the first deep breath of her life. The asthma had broken. She took a deep breath that seemed to "...extend down to my toes. " I felt like I was breathing, that I had taken the first breath, the first deep clean breath I had taken in my entire life." At that moment she knew that she would never be sick with asthma again. "It was gone. All the wheezing stopped and all the coughing stopped and my lungs were clear. I could breathe again." But she still felt trapped in a sewer.

So they kept on with the birth regression. The

attendants were plying her with pillows and adding pressure. This made her feel more and more trapped. "I went ballistic." She felt like she was trapped, crushed, and suffocating. She had the sense that she had to be "big" or she would be crushed, and she would be killed. She felt like she was being beat up. She hurt all over. She was exhausted and there was no one to help her out but herself. She was on her own. When she finally crawled her way out of the womb in a second regression, she discovered feeling depressed, sad, and underneath, angry.

Amy / Themes

Anguished Emotional, Physical, and Feeling States
A Perception of Mother's and Others' Reality
Feeling Overtaken or Trapped by the Experience Itself
Relief or Healing

Summary

A young woman living in San Francisco, Amy, who was adopted as a baby, has faced emotional challenges that most others have not. As an adult, for example, she elected to meet her birth mother and father, and birth grandparents as well, not knowing what to expect from them. Her birth mother was not receptive. "She couldn't handle it," says Amy. But her birth father, and paternal grandparents welcomed her. This left her feeling, "exhilarated," and according to Amy, allowed her to, "open up in a way she never had before." Shortly after this Amy had a relationship where she cared open-heartedly for another, for the first time in her life.

This liaison lasted for about 2 years, when her lover broke it off, saying that she had to be by herself. Amy describes the break-up as, "excruciating." She accepted her partner's decision, but could not understand why she wanted to separate. There didn't seem to be any reason for it. Nine months later, however, she learned that her lover had been having an affair.

Counting back from the time of year her partner broke up with her to the time of year of her conception, is a 7 month span. Amy explains that she was 7 months in utero when her birth mother decided to place her for

adoption, "to go her own way." This decision was due largely to the fact that her birth parents were in the midst of an illicit affair which her birth father had decided to end. Amy's birth mother was devastated by his decision.

These events had taken place at the same time of year that Amy's partner had decided to split up with her. Just as her birth parents had been having an affair, so had her partner. While she had become aware of her birth parents' affair after meeting her birth father (about 2 years before this relationship), Amy didn't realize the impact their experience had had on her, nor the effect it was still having in her life. The following experience allowed Amy to really work with her feelings around the break-up, and change a destructive relationship dynamic that had become a constant.

One early morning, about 1:30 a.m., shortly after the break-up with her partner,
Amy awoke to find herself in the fetal position in "excruciating" pain. She was in so much pain that she felt as though she might die. But Amy stayed in the position, and stayed with the pain, asking herself these questions. "Why am I in the fetal position in such agony? What does this have to do with me?" Amidst intense feelings of abandonment and betrayal, Amy felt her awareness suddenly spiral open. She began to realize that everyone she had ever been involved with had been having an extra-relationship affair. She describes herself as having been in "denial" about it to that point.

So Amy confronted herself with another question, "Why? Why am I always picking people that are lying to me?" She stayed with that and the feelings of abandonment and betrayal until she realized she was replaying her birth parents' story.

Amy describes feeling as though she could not extricate herself from this experience. She felt trapped in it physically and emotionally and had to let it play out to its finish. She believes that the prenatal memories became conscious at that time in her life not only because of the break-up of her relationship, but because she had an excellent support group of good friends who could assist her with the integration of the feelings and awareness. She also thinks that the emotions she encountered in herself would have been too powerful to handle as a pre-born

infant.

She describes not being able to breathe and feeling as though she would die. Memories of attempted abortions surfaced, along with the feelings of abandonment and betrayal she believes she had at her mother's decision to give her up, and that concurrently, her birth mother was experiencing at the break-up of the affair with her birth father. Amy relates that these memories were in her body, which is why her body positioned itself in a fetal pattern.

The healing rewards that occurred as a result of Amy's courageous confrontation with her prenatal past have to do with her ability to maintain a mature and intimate relationship with another human being. At the beginning of the 7 year relationship she is currently in, her partner discussed having desires to be with someone else while being with Amy. Amy told of being able to handle this situation successfully by refusing to permit any extra-relationship activity of any kind. Accordingly, this led to her partner's discovery of the roots of the need to stray, and had the affect of deepening their love. Amy says that taking a stand like that was not easy, but that she has been able to do so for two reasons, first because she allowed herself to feel all the unresolved feelings to completion, and secondly, because she has become so clear as to where the relationship pattern developed, and how destructive it has been.

Apparently, the pattern of extra-relational affairs has been family-wide. It seems that Amy's sister's ex-husband had had an affair with a woman named Rose (Amy's birth mother's name) which caused the break-up of their marriage. Finally, according to Amy, her birth father usually continues the pattern as he has been involved in extra-marital affairs during most of his adult life.

An added blessing for Amy as a result of her pre-birth remembrance is that she is able to follow a career path, running workshops that assist others to reconcile personal issues arising from pre-and perinatal experience.

Jesse

Themes

Anguished Emotional, Physical, and Feeling States
A Perception of Mother's or Others' Reality
Relief or Healing

Summary

Jesse is a family man. He lives with his wife and two teenage children in the Sacramento area of California. Jesse never believed in nor had any experience with the remembrance of birth, or any other metaphysical phenomena. In fact, if he hadn't become ill with a mysterious and painful condition, he still would not believe in the relevance of pre-and perinatal memory. This is his story.

After about 3 months of unrelenting pain on his right side, Jesse sought medical advice. He was admitted to the hospital and for 3 weeks run through a gamut of medical testing. Nothing was found. Some suspicion of kidney problems existed, but that proved unsubstantiated, as well. The doctor gave Jesse Vicodin for the pain, and sent him home. That's when his friend, Max, showed-up.

Max asked Jesse if he wanted to find the cause of the pain. Jesse replied in the affirmative. "What did he have in mind," he wanted to know? Max had been teaching a class in the art of, RFA, or Relaxed Focused Attention. It seems he had been able to help many people to resolve trauma using a technique called, "muscle testing," where questions are asked about the "when" and "what" of a particular problem, and the arm is forced downward to reveal an answer. He began to use this process with Jesse.

By muscle testing him for the "when" of his problem, Max discerned that it had begun in the third trimester of Jesse's prenatal life. At the instant he tested positively for this period of time, Jesse felt his whole right side light up in pain. "What just happened," queried Max? "I wish I didn't have to tell you this," replied Jesse, "but I just saw my father slug my mother in the Stomach, and she's 7 months pregnant with me." Max kept asking the questions and Jesse kept having the memories. "Why does he do it?" "Why does he hit you?"

Jesse became physically in touch with his father's anger, and had a deep understanding of how he became angry. Many times he found himself sobbing uncontrollably in response to the realizations. He described it as, "an incredible release of energy."

With the awareness that Jesse's side pain stemmed from the violence he'd experienced in the third trimester of life, Max encouraged Jesse to release the energy he held around the experience. At Max's acknowledgment of this Jesse was able to release the energy. Within a few hours of this release the pain was mostly gone. The next day it was gone entirely and has not returned to date.

Since that time, about 3 years ago, Jesse has recounted many of the memories to his mother. He had 8 to 10 specific memories to check out with her and of those she validated 8. This included that his Dad had hit her in the abdomen during the seventh month of pregnancy.

APPENDIX K

Follow-Up Question ; Answers to the follow-up question are presented below. What about your pre- and perinatal remembrance was healing for you?

Marisa

Marisa: Well it's been healing primarily because I learned about the beginnings of a number of life-long patterns that I had repeated over and over again. And I'll say what they are but this is not in order. One that just occurred to me...that jumped out after telling you about the nurse was that I always attempted to attach myself to motherly women throughout my life. Some of them were people like employees of my mother. There were two maids that worked for my mother and I followed them around. And I learned all about their lives and their families and their kids. And I was just like a little person who trotted after them trying to make contact. And I remember when I had that suicide attempt, I was in the hospital and the doctor interviewed my mother as part of the record which I found later on. And the doctor asked my mother what kind of a little girl I was. And

my mother said that the maid had loved me. And so it kind of reinforced my own recollection that it was them and not my mother that I was attached to, since that same thing came out of her mouth. And so I didn't make it up.

And, let's see, another pattern that I repeated over and over again was having difficulties attaching to my homes, like the difficulties in attaching to the uterine wall. And now that I know what it is, it's easy to let go of it. So, when I moved into the place where I live now, for example, I had a hard time feeling like I belong here. Even though I moved a lot of my stuff in here and did everything I could to make it seem like home it just took quite a while for me to feel that it was home.

Interviewer: What about when you leave somewhere?

Marisa: Well, actually, that's another pattern. Leaving is a lot easier for me. And so I get that, "I gotta get out of here feeling." And nothing will stop me. I'm just bound and determined to leave. So what happens is that I attempt to attach without a lot of thought, that's been my pattern. I attempt to attach without a lot of wisdom. And then I have a lot of difficulty. But that's been a pattern in relationships throughout my life.

Interviewer: So like you attach to somebody because they're close to you and you need someone, and then you leave kind of abruptly?

Marisa: And then it just doesn't work out and I make a decision to leave and I'm the one who ends it. So I guess that's the major...or one of the major patterns that's come out of my perinatal experience, is a difficulty in attaching to people and places, mostly people. And a difficulty with intimacy. 'Cause I really feel like I'm supposed to be alone and that I won't be really wanted.

Interviewer: And you use this material to work on that?

Marisa: Yeah. Oh yeah. I have used it. And it's been a tremendously persistent thing...it's very hard. And another thing is kind of life-long depression. That comes from feeling like I'm not...there's something wrong with me because I wasn't wanted. So that's that one. That's also been pretty persistent and hard to shake. And in spite of a lot of therapy and even with the pre-and perinatal awareness, it's not gone. Now

it's more habit and thought than anything else. But when I catch myself I can say, "Oh it's that again." And I can get out of this feeling of hopelessness and wrongness a lot easier. And then there's the bargain that I made with my mother. I often, over the years, felt suicidal. And I really nearly did succeed once.
Interviewer: And... Is this hard for you?
Marisa: Yeah. Well, that's that and it's true. I felt really, really sad and really alone. And another pattern was trying to be good. That was my response to try to sit on my own emotions and needs as much as possible. Someone who needed nothing. That was the only way that I could figure that I would be loved was if I didn't need anything. So that's been another one.

Interviewer: That's interesting. Someone else might decide that they needed to make a lot of racket or something.
Marisa: Right, right. It is interesting. Other people have totally different reactions, and I'm really aware of that, to the same feeling. Another huge pattern, of course, was drugs and alcohol. And in my case, I sought to escape the alcoholism of my parents by becoming a drug addict. [laughs] I thought it was different. So I was addicted to marijuana from after my suicide attempt and for the next 23 years. So I numbed myself out with that. And that certainly contributed to my failure to deal with all the "mother" stuff. And to my difficulties with relationships and my depression. So I did get into recovery 11 years ago, but that was before I had any awareness of the perinatal stuff. But getting into recovery started me on a path of healing that culminated in being involved in Pocket Ranch and Star and all that stuff.
Interviewer: So would you say that the healing then for you was that these pre-and perinatal experiences provided you with tools to work on your long standing issues?
Marisa: Yes, yes, that's part of it. Another part of it is that I gained a spiritual awareness of my purpose through this work. And of my light, my holiness. And that has been a tremendous help to me.

Douglas

Douglas: A lot of symptoms have disappeared over the last 5 or 6 years.
Interviewer: Like what?
Douglas: Oh, like...my depression is probably 95% gone, and the blackouts are gone entirely. I'm finding myself able to relate a lot more to my own feelings and people in general. I don't feel nearly as isolated and lonely as I used to feel. The migraines are gone and the obsession I had to twist and float is also gone. And now I'm a pilot, and not a "white knuckle" pilot! I really enjoy it without the panic. And I don't push myself. I push myself about 80% less than I used to. I'm a lot easier on myself. I don't have a need as much to prove I'm okay. I was countering those feelings of my mother rejecting me in utero by trying to prove to the world...actually trying to prove to myself that I was really okay.
Interviewer: Well I thank you ever so much for your help.
Douglas: You're very welcome. I'm glad I could be of help to you. [laughs] It's nice to have somebody get something out of all the shit I went through.
Interviewer: Yeah! And you have been through a lot! And what's amazing about it is that it's manifested so tangibly.
Douglas: Yeah, it really has. It makes a pretty interesting story when I hear it read back to me.
Interviewer: Well most of us can say [about psychotherapy], you know, "I'm not as depressed as I was." Or, "I've grown." Or something like that, you know? Not the
tangible stuff though, like, "I can fly." [laughter]
Douglas: I can flip and turn around backwards!

Karlton

Karlton: Well, the healing itself, okay, I had this vision change. My eyes got better. But it was more than that. It made me realize that there's something magical about life and the physical body. I wouldn't have acknowledged that unless I had experienced it personally. And if someone had told me that story back then I would've thought they were just bullshitting. But the healing was realizing that I can reexperience deep, deep, deep information that was imprinted on a

deep level into my physical body. And by doing that and knowing, as a conscious grown-up, what happened, what my memory was, feels like an absolute truth, not something you make up. Not something you remember in your head.

What is healing to me is to reexperience that as a grown-up and give myself information and love myself and know that when I have a situation with lots of stress and lots of pressure that I have options. We don't have to go in that same pattern. I don't have to live my life the way I was born. I have options and so knowing you have options I am more conscious of who I am and how I am and what happens to me in situations. So it's about becoming more aware or more conscious I guess you could say of how I respond to the world. The healing was more than just the eyes changing. It's knowing that I can learn things about myself I never thought were possible. And I just get really turned on by that.

Caroline

Caroline: Anger. I healed a lot of anger that I held toward my mother. 'Cause I held her responsible for my birth pain. And that's simply because the infant has no one else to blame, that's all they've known. And so I held her responsible. A lot of anger held at my mother I was able to let go of.
Interviewer: How's your relationship with her now?
Caroline: Well, I don't speak with my family. Because of the sexual abuse. And I confronted my dad very gently in a letter and they broke off there. They said I was mentally ill. And they'd like to kill Dr. C. and things like that. You know, the usual. And it wasn't done in a nasty way. Just that I wasn't going to lie anymore and pretend. No, there's nothing there and actually that's okay. There are certain things that you can forgive but you don't have to put yourself in their path again. That's what I've done with this. I would go into a state of panic just thinking about seeing them, either one actually. My mother beat me also, so...Yeah, I kinda have everything that could happen to a child.
Interviewer: You also cured yourself of the phobia of being poisoned by your food...and the fear of dying from lack of air?

Caroline: Yes.
Interviewer: And the arthritis?
Caroline: I had had it. I still have some trauma at the very core of my frame. People just can't believe that at 19 I was, you know, crippled. They can't believe that I'm almost 47. [Laughs] A woman asked me for my student ID the other day. I could have kissed her. They think I'm the healthiest thing they've ever seen. It all left. With each memory more and more of it would leave. I feel as though the majority of the arthritis that I had throughout my entire body left after recalling my birth memory and having the releases that came with having those memories.
Interviewer: Is there anything else you would like to say?
Caroline: Just that birth affects us in ways that we can't even begin to imagine, until we take the courageous step into looking backwards to our beginnings. We do that by accessing the subconscious with the help of therapists such as Dr. C. or Dr. F. And then the birth and the trauma that is created for us loses the control it has on our life. If we'll face it, have the courage to face it.

Rachel

Rachel: Well, I have been relieved of about 98% of my asthma. I had one bad patch last winter, and it was specifically related to some emotional stuff I was going through at the time. But I'm pretty much not on any meds right now. I'm on two preventive inhalers and that's it. And I forget to take those half the time. I have not had to take oral steroids since then, at all, period, which is a major, major shift in my life. Um, I would no longer define myself as a steroid dependent asthmatic. I would no longer define myself as a brittle asthmatic which I certainly was before. And I am no longer under the weekly, monthly care of a pulmonologist. I still have a pulmonologist that I check in with, just as back-up. You know, in case something falls apart. It [the asthma] is still a little bit there. It's still a little bit there. I had some trouble earlier this year mainly because I was not taking care of myself. And was having, doing a little wheezing and stuff like that. But I mean it's very, very, very low key. Especially compared to what

went on before. You know, the repeated hospitalizations, the critical care and the management , the incredible drug therapies I was under. You know, my life is really different, really different. And I can do stuff now that I couldn't do before. Because of the birth regression. I can do hiking, I mean I go slow, but I can do hiking and outdoor stuff that I couldn't even attempt before. So my life is real different as far as that is concerned. And my immune system has been strengthened. I mean before the birth regression, before STAR, I had a lot of allergies particular to pretty normal stuff, dust mites and various food allergies. And I find myself much less reactive or not reactive at all anymore. And I just really had the feeling during the birth regression that my immune system kicked in for the first time. That somehow it had been totally depressed. I felt that my immune system had been really depressed and really pushed down. And it certainly was with all the steroids. [laughs] I mean steroids will do that for you real quick. I mean I'm still dealing with the aftermath of that.

Amy

Amy: I cleared up a relationship pattern so now I don't have to deal with my partners having affairs anymore. You know that was pretty big.
Interviewer: Right, that's huge.
Amy: And its lasted too. It's not something that's gone by the wayside.
Interviewer: Right.
Amy: Also I understand my past better. So I have greater self-understanding.
Interviewer: And it sounds like you got some direction into your career.
Amy: Oh yes that's a good point.
Interviewer: 'Cause you followed that lead into doing this professionally, yes?
Amy: Right, right.
Interviewer: Do you feel like it's affected your life in terms of self-esteem and overall life satisfaction?
Amy: Yes, definitely. Because it was an experience that I went through and I have a lot of good feelings for myself because of that. And also if it paved the

way for you to have a long-standing relationship, that's pretty profound.
Interviewer: It certainly is.

Jesse

Jesse: More important than the pain was...I've always had this hatred for my dad. And I'd even, after going through some awareness trainings, I don't want to say confronted him but just expressed that I had this feeling and I don't understand it. Thinking that voicing it somehow would release it, you know. And it never would go away. And I used to be just driving in the car wishing he were dead. Like it would get rid of all my pain if he were dead. And then I'd feel guilty about that, because how am I going to feel at his funeral? You know, wishing he were there and he's dead. So the most healing that took place is that that totally went away. Not all the anger, but the wishing he were dead. So even more than the pain that went away in my side, the freedom that occurred there was incredible.
Interviewer: Is there more?
Jesse: No. You've captured, basically, the experience.