The Role of Prenatal Trauma in the Development of the Negative Birth Experience

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Full Text: Headnote ABSTRACT: In this paper the author reviews and extends his previous researches into the negative birth experience. He notes that the incidence of the negative birth experience is constant at about 30% even in asymptomatic individuals who on further enquiry admit to restrictive feelings which have effectively limited their access to a full potential. The prominence of the negative birth experience in the production of certain symptom complexes is detailed. The negative birth experience is therefore to be considered a potent inhibiting factor to be dealt with therapeutically wherever it is discovered. In a consecutive series of 260 patients 76 (29%) indicated that they had negative birth experiences. Of these 48 (63%) reported prenatal experiences responsible for their negative feelings at birth. Some of these experiences are described. An investigation into the 61 cases of depression (having a high negative birth experience incidence of about 40%) reveals a high incidence of prenatal trauma of 77% in the 26 with a negative birth experience. These figures suggest that almost 20% (probably nearer 30% for cases of depression) of all patients attending for psychotherapy suffer from symptoms due at least in part to prenatal trauma. It is further postulated that this 20% is likely to remain inaccessible to psychotherapeutic approaches that ignore the role of prenatal trauma. Introduction In 1972 I first met Dr. David Cheek and was profoundly impressed by the ease with which he was able to uncover birth memories by means of the ideomotor signal and ideomotor questioning. Over the years I have taken every opportunity to familiarise myself with these techniques and have become increasingly convinced that memories uncovered in hypnosis are factual in most cases. Support for this view has come from my own practice in which on occasion there has been the opportunity to validate such birth memories with the subject's parents. Cheek (1974) described the appearance of sequential head movements during regression to birth. The accuracy with which these movements reproduced the probable movements due to the birth process, provides conclusive evidence of the validity of regression using his techniques. Chamberlain (1980) compared the birth memories of 10 mother/child couples and found that they shared a wealth of factual detail in a high proportion of cases. From this evidence Chamberlain concluded that birth memories are real although he admits that the possibility of falsification exists. However he affirms that the quality and content of these birth memories are such that they give clear evidence of the newborn's ability to experience, learn, understand and form relationships from the commencement of extrauterine life. There is evidence to support the belief that the newborn is able to respond specifically to the environment in which he finds himself. Meltzoff and Moore (1977) have conclusively demonstrated that the newborn has a detailed awareness of his environment immediately after birth that one can reasonably assume must have been established prior to birth. Harris (1967) cited evidence to prove that the events of birth and of infant life are recorded even though they are not remembered. There are certain factors surrounding birth that appear to have a profound effect upon later life, chief among which are the anxiety and rejection of illegitimacy. Stott and Latchford (1976) found that illegitimate or premaritally conceived children have a 44% greater risk of morbidity than the average. The adopted child runs this risk since he is nearly always in this category. Stewart (1955) found that there was twice as much prematurity and three times as much perinatal death among extramaritally conceived children and James (1969) pointed out that illegitimate infants are at a greater risk of being stillborn indicating that maternal psychological stress is responsible for some of this additional risk. Anxiety can of course be due to other factors and Davids and DeVaults (1963) demonstrated that birth complications were more frequent in seriously troubled women all of whom in their study had at least one complication whereas the normal controls had none. Lederman and Lederman (1981) noted that maternal

conflict regarding the acceptance of pregnancy also correlated significantly with the newborn's five minute Apgar score. Anxiety in labour and the plasma epinephrine correlated with the fetal heart rate which in turn correlated with the Apgar score. They concluded that conflicts during pregnancy are predictive of maternal anxiety and stress related biochemical factors. These variables are related to prolonged labour and to fetal/newborn depression. Netter (1982) confirmed that psychoneurotic factors were responsible for rejection of a pregnancy and that this showed an association with the infants' later development of aggressive or regressive tendencies. Klaus and Kennell (1972) performed studies on the "bonding infant" (one whose relationship with his natural mother had been established) and found that they became more self-sufficient and outgoing than those infants who were taken from their mother immediately after birth before such bonding could be established. Rosenthal (1966) demonstrated that the perinatal environment is of far greater importance than genetic factors in the development of schizophrenia in the children of schizophrenic parents. Greenacre (1952) stated that the birth procedure in the human can be considered as fear arousing and traumatic in most instances. DeSousa (1974) agrees with this view but points out that the process of birth is a trauma which takes an even greater toll on the infant in an abnormal birth. Read (1951) developed a new approach to labour based on an assumption that attributed the most difficult labour to fear and in further support of this view Cramond (1954) was able to relate dysfunction in labour with a dysfunction temperament in 54% of cases as compared to 12% of controls. In another important paper Cheek (1975) in reviewing birth memories made an excellent case for concluding that the newborn can respond to maternal stress with persistent feelings of guilt which could initiate a behaviour pattern likely to produce symptoms of illness later in life. Prior to learning of this research I had been puzzled by the frequent recurrence of symptoms in patients who had initially responded extremely well to analytical hypnotherapy and yet, for no apparent reason, had later relapsed. At that time in my career I had not been concerned with evaluating the birth experience in my patients but following my meeting with Dr. Cheek I decided that I should make a determined attempt wherever possible to discover the nature of the birth experience in every patient. It was not long before I was to learn from many of my patients that they had retained a negative feeling about their birth experience in which a predominant sense of guilt for being born had persisted at an unconscious level. With the use of analytical methods to encourage them to rid themselves of this now irrelevant guilt most of these patients became permanently symptom free. In a previous paper (1979) I have described how one patient with recurrence of migraine following what had appeared to be adequate therapy was ultimately completely freed of symptoms and how another patient with recurring depression also became permanently free of symptoms only when the guilt associated with his birth was relinquished during hypnosis. In 1976 I began to investigate the relationship of the birth experience to illness in greater detail and for the next three years attempted to discover the unconscious feelings that each patient had about his or her birth experience. This was accomplished in the manner advocated by Cheek in probably 95% of those attending for hypnotherapy. Each patient was trained to develop unconscious ideomotor finger signals to indicate unconscious answers of either "yes" or "no". Using this method of ideomotor questioning, questions were directed to the patient's unconscious memory to determine whether the birth experience was recalled as being satisfactory. When the signals indicated that the birth experience had been located a question was then put as follows: "Babies when they are born know many things and the baby, Jane, knows many things. One of the things that she knows is whether she feels okay about being born. If she feels okay about being born, the "yes" finger will lift but if she does not really feel okay about being born then the "no" finger will lift." In a series of 876 patients whose birth experiences were examined in this manner 631 (72%) gave a positive response and the remaining 245 (28%) indicated that they still unconsciously retained negative feelings about their birth (Figure 1). The fact that almost 3 people in 10 presenting for hypnotherapy should have a negative birth experience in itself indicates that this problem is of considerable significance. At the time of this study I suspected that this figure might be artificially elevated simply because the population under study was a selected one with overt symptomatology. Since then, however, I have had several opportunities to do similar surveys on "normal"

populations (namely groups of students and therapists at workshops that I have conducted) and I have been surprised to discover that a similar percentage (about 30%) of negative birth experiences is consistently found even in these apparently asymptomatic groups. I have since heard from other colleagues that their findings in similar circumstances have been identical.

	Positive	*Negative*	*Total*
Male	143(76.5%)	44(23.5%)	187
Female	488(70.8%)	201(29.2%)	689
Total	631(72%)	245(28%)	876

Figure 1. Sex and the Birth Experience

It would therefore appear that the negative birth experience may either be asymptomatic or be responsible for symptoms which are thought to be insufficiently severe to require therapy. I believe that there may be many apparently emotionally healthy persons who are functioning far below their potential because of the handicap of a negative birth experience. When the relationship of the negative birth experience to various clinical parameters was subjected to detailed examination some interesting information emerged. For example, it was discovered that there was a significantly higher incidence of the negative birth experiences among females (201/689 or 29.2%) than among males (44/187 or 23.5%) (Figure 1). When seeking the reason for this evident sexual bias one might easily speculate that this difference in sex incidence could be due to a generally greater social acceptability of the male child. On investigating the presenting symptomatology it was noted that there were certain groups that were characterized by a more than average (30%) incidence of the negative birth experience (Figure 2). For example in a group of 11 cases presenting for treatment of alcoholism 5 (45%) indicated that they had a negative birth experience. This high incidence is probably related to an underlying depression since out of 77 cases presenting with depression, 29 (37.6%) had a negative birth experience. My subsequent clinical experience leads me to suspect that all who have a negative birth experience are likely to be subject to otherwise unaccountable periodic feelings of depression. These can readily be understood as being a probable consequence of the rejection associated with the negative birth experience.

	Positive	*Negative*	*Total*
Alcoholism	6(54.5%)	5(45.5%)	11
Anxiety	105(65%)	57(35%)	162
Depression(A)	16(61.5%)	10(38.5%)	26
Depression(B)	32(62.7%)	19(37.3%)	51
Depression(A + B)	48(62.3%)	29(37.7%)	77
Divorced or Separated	64(64%)	36(36%)	100
Marital Problems	7(58%)	5(43%)	12
Asthma	6(86%)	1(14%)	7
Phobias	25(86%)	4(14%)	29
Nailbiting	7(50%)	7(50%)	14
Hair Pulling (Trichotillomania)	0(0%)	4(100%)	4

Figure 2. Presenting Symptomatology and the Negative Birth Experience

Of the 162 who presented with anxiety 57 or 35% indicated that they had experienced a negative birth. This high incidence is a logical consequence since one would expect that negative feelings of rejection persisting from birth into adult life, would be the probably source of marked feelings of insecurity evidenced by anxiety. It was also noted that there was a strong relationship between unsatisfactory marital experiences and a negative

birth experience. Of the 100 people who reported that they were separated or divorced from their spouses 36 (36%) indicated that they had negative feelings about birth. One can postulate from this that those who do not feel good about themselves are more likely to experience the kind of emotional difficulties that can impose a severe strain on the close relationship of marriage. Of 12 people attending specifically for therapy for marital problems five gave an indication of a negative birth experience. Although admittedly this is a small sample, this high incidence of 42% once again suggests that successful marital relations demand positive feelings that are less likely to be present in those with negative birth experiences. As might be expected, statistically, there were certain categories of patients whose incidence of the negative birth experience was well below the average of 30%. A striking example of this was the group of 29 phobics of whom only four gave a negative birth experience. This extremely low incidence of 14% was matched by the small group of asthmatics in which only one of the seven recorded in the study gave a negative birth experience. The logical conclusion to be drawn from this is that the critical experiences responsible for symptoms for these groups are more likely to occur in later life although it is difficult to surmise why this should be so. We were surprised to discover that the apparently innocuous habit of nailbiting was associated with a very high incidence of negativity regarding birth. Seven of the 14 in this study, i.e. 50%, responded with negativity about the birth. However when four cases of hair pulling were also all found to give a negative birth experience, nailbiting can similarly be interpreted to be evidence of unconscious aggression against a self-regarded as unacceptable since birth. Another objective of this study was to determine whether there was any relationship between hypnotizability and the birth experience (Figure 3). We were interested to discover that, of the 440 patients whose trance depth was rated, there were 47 who were only able to achieve a very light trance (Grade 1) and of these 47, 19 or 40%, had a negative birth experience. Most hypnotherapists would agree that hypnotizability is directly related to an individual's capacity to trust. It can therefore be assumed that the rejection of a negative birth experience would severely limit one's capacity to trust so that in these cases the deeper levels of hypnosis would be more difficult to achieve. Even before these results were available I had concluded, as had Cheek so many years before, that the experience of birth was an important and critical experience for many who attend for hypnotherapy. It appears that even at this early age the newborn is able to make decisions which will have a profound effect on the future course of his life. These decisions presumably remain buried deeply in the unconscious memory but nevertheless continue to control the individual's responses to his environment in a manner which can later prove inimical to him. Therefore for those whose symptoms in whole or in part result from a negative experience at birth, an effective modification of these symptoms can only be initiated by a clinical approach that is able to communicate with and modify the memory of this experience. In hypnosis not only can these old decisions be located but suggestions can be given to alter them appropriately.

Depth	*Positive*	*Negative*	*Total*
1	28(59.6%)	19(40.4%)	47
2	138(69.3%)	61(30.7%)	199
3	78(73.6%)	28(26.4%)	106
4	57(74.0%)	20(26.0%)	77
5	7(63.6%)	4(36.4%)	11
Total	308(70.0%)	132(30.0%)	440

Figure 3. Trance Depth and the Negative Birth Experience

In this series of cases the outcome of analytical hypnotherapy was subjected to an evaluation not only by the therapist but also by the patient six months or more following termination of therapy (Figure 4). These results indicated that when the birth experience was treated therapeutically like any other critical experience the response to therapy was as good for those with a negative birth experience as for those with a positive birth

experience. It must be presumed that the symptoms of this latter group resulted from other later critical experiences. In this study 319 patients evaluated their response to therapy six months after its termination. Of 220 with a positive birth experience, 50 claimed complete success-a percentage of 22.7 and an almost precisely equal percentage (22.2%) of the 99 professing a negative birth experience also claimed complete cure. When those claiming a partial success from therapy were considered the figures maintained an identical similarity namely 41.8% (92/220) for those with a positive birth experience as compared with 42.4% (42/99) of those with a negative birth experience. In therapy the negative birth experience was dealt with in precisely the same manner as any other critical experience. It was located and reviewed at an unconscious level using the ideomotor signals and then the current adult understanding was accessed and applied to the experience. It would sometimes be necessary for the therapist to offer the assistance of his own adult wisdom by suggesting the many other factors that might be responsible for the unsatisfactory circumstances of the birth and for which the patient need no longer continue to accept blame. In the majority of cases this approach was successful and the previously negative birth experience could now be viewed as being largely positive. Thus even though, for example, the birth may have occurred at an inopportune time it could be pointed out how things had since worked out satisfactorily. The assumption could now fairly be made that the patient has a perfect right to be born and his birth could now be considered as proper in every sense of the word. However there have always been patients who resist every effort to persuade them to accept these suggestions for relinquishing guilt whether this guilt be associated with birth or some later critical experience.

Birth Experience	*Complete Success*	*Partial Success*	*Failures*	*Total*
Positive	50(22.7%)	92(41.8%)	78(35.5%)	220
Negative	22(22.2%)	42(42.4%)	35(35.4%)	99
Total	72	134	113	319

Figure 4. Therapeutic Outcome and the Negative Birth Experience

Early in my investigations of the negative birth experience I was occasionally able to obtain a verbal description of the experience and the reasons for its negativity. In some cases it was because mother was unconscious during the delivery and thus unable to welcome the baby in an appropriate manner. The baby had subsequently felt responsible for mother's helplessness. Sometimes the mother was recalled as being in great distress during the delivery and the baby had accepted responsibility for this pain. In other cases it was because the mother would not or could not accept the baby and give it the necessary affection. This would frequently be the case where the baby was subsequently adopted. Incidentally, I have been impressed by the frequency of depression in adopted persons and this appears to be directly related to the rejection implicit in the adoption procedure but I have not yet investigated this frequency statistically. Occasionally father was remembered as being strong in his disapproval of the newborn, subsequent symptoms apparently being the results of efforts to regain his approval. Frequently however the feeling of guilt and other unpleasant emotions had evidently begun prior to birth and some patients would describe hearing mother or father emphatically stating a strong opposition to the child. This was often experienced as something deeply felt rather than something actually heard. It was therefore assumed that a significant proportion of infants with negative birth experiences attain a state of negativity some time prior to birth as a direct result of experiences undergone while in the uterus. The objective of this paper is the examination of the incidence of these prenatal experience as a source of the negative birth. Feher (1981) emphasises the fact that every individual comprises all that came before birth as well as all that follows it since birth is merely a bridge to a new dimension of life. Feher also believes that certain personality structures relate to specific birth experiences. Hau (1979) comments on the increasing interest in this area in Germany where

previously there was little evidence of any notable scientific contribution and points to Greber's valuable contributions to the understanding of prenatal psychology. Verny (1977) in his review of the literature on the subject, cited many examples of the effect of maternal stress upon the unborn child, and pointed out that many investigators attribute infantile autism to intense maternal anxiety during pregnancy. Sontag (1941) suggested that chronic fatigue, malnutrition and strong emotional disturbances may so alter the physiology of the pregnant woman that the fetus is adversely affected and Frank (1966) believed that a woman bearing an unwanted child may be so unhappy and disturbed that she may be said to have a hostile uterus. Verny (1981) found that the most commonly reported womb feeling was peacefulness but this was closely followed by reports of anxiety as a common womb feeling and Sontag (1960) described several cases where maternal anxiety resulting from severe stress was frequently accompanied by a great increase in fetal activity. Ploye (1976), in discussing the evidence for prenatal intrauterine experience and the capacity of the fetus for learning, expressed the belief that a variety of extra and intrauterine influences can have a strong bearing on the quality of intrauterine life. Taylor (1969) had previously found that the influence of psychosis on the fetus could be profound particularly if early in pregnancy. He discovered that if the mother becomes psychotic within one month of conception a male embryo may be destroyed. If the mother becomes psychotic between the second and third months the fetus either develops an abnormality or dies slowly. Liley (1977) presents the view that the fetus has distinct personality characteristics and is not a passive organism but rather is a dominant partner in the pregnancy role. Many researchers have uncovered buried memories of prenatal life. Grof (1976) described a prenatal memory of a man who recalled a carnival which was taking place just prior to his birth. There is much evidence to support the belief that such memories are valid and that the fetus is able to experience and record events of prenatal life. Salk (1966) makes a strong representation for the role of imprinting in early human development and feels that it is important to explore further the elements of prenatal sensory experience in the human. He has shown how the sensory impressions from the maternal heart beat are imprinted during prenatal life. Liley (1972) discovered that the fetus will move in rhythm with the beat of a drum and will also respond as early as ten weeks in utero to pressure placed upon the abdomen of the mother while Sontag and Wallace as early as 1935 demonstrated that the fetus responds to sound vibrations applied to the abdomen of the mother. Beadle (1970) has even suggested that the fetus has a well developed sense of sight and imagery which is limited to distinguishing light from dark. In a recent series of 260 patients attending for therapy 76 (29%) indicated that their birth experience had been negative (Figure 5). Of these 76 the following question was then asked, "Does this uncomfortable feeling begin before being born?" Those patients who indicated that the experience causing the feeling of negativity about birth actually occurred before birth were asked to review it at an unconscious level using ideomotor signals. They were then persuaded to apply modern adult wisdom to that experience. In a significant proportion of these cases there was an excellent response to further suggestions for the reduction or elimination of these old, and currently irrelevant, negative feelings.

1. Incidence of Negative Birth Experience

	Positive	Negative	Total
All	184(71%)	76(29%)	260
Depression	35(58%)	26(42%)	61
Anxiety	70(64.3%)	39(35.7%)	109

2. Incidence of Prenatal Trauma in Those With a Negative Birth Experience

	None	One or More	
All	28(37%)	48(63%)	76
Depression	6(23%)	20(77%)	26
Anxiety	13(33%)	26(67%)	39

Figure 5. Prenatal Trauma and the Negative Birth Experience

Of the 76 patients with a negative birth experience the surprising finding is that 48 (63%) had a prenatal negative experience responsible for, or contributing to, the negative birth feeling. It can therefore be assumed that a significant proportion of those presenting for psychotherapy have problems owing their origin to stresses or traumata occurring prior to birth. If this is indeed so it must also be assumed that this substantial proportion of patients attending for therapy cannot be assisted by approaches that ignore prenatal influences. An especial examination was made of those patients who presented with the common diagnosis of depression or anxiety as either the main or secondary complaint. Of a total of 61 who complained of depression there were 26 patients in this series later found to have a negative birth experience. Of these no less than 20 (77%) gave evidence of a prenatal negative experience. Of the 109 patients presenting with anxiety as the chief or secondary problem 39 had a negative birth experience of whom 26 (67%) also had a contributory negative prenatal experience. These figures indicate that, approximately two-thirds (48/76) of the 29% of patients presenting for therapy who have a negative birth experience also have a prenatal experience contributing to this state of affairs. We can conclude therefore that almost 20% (48/260) of all patients attending for therapy have a prenatal negative experience probably responsible in whole or in part for their symptoms. This proportion is somewhat higher (26/109 or 24%) for those presenting with anxiety and significantly higher (20/61 or 33%) in those cases suffering from depression in which it probably reaches the order of 30%. Should these findings be confirmed by other observers it can reasonably be assumed that, since it cannot deal with those problems the origin of which is to be found so early in life, conventional psychotherapy must fail in a high proportion of these cases. As a general rule it has proved unnecessary to bring a prenatal memory to a level where it can be verbalised, but there have been several instances where verbalisation has occurred. This permits a therapeutic insight into the kind of conflict responsible for the prenatal trauma. In one such case a male patient who presented with anxiety gave a graphic description of a motor vehicle accident in which his mother was involved as a passenger while pregnant with him. It would seem that her fear had been internalized and communicated directly to the foetus to such an extent that it had been retained unconsciously until commencing therapy. He was able to deal with this experience as with other critical experiences simply by applying his present wisdom and understanding to emphasize that he was not, and had never been, responsible for his mother's feelings and therefore need no longer retain them. In another case a 26 year old nurse who had originally attended for help in losing weight and had enjoyed a temporary success, returned seven years later. At this time she was severely depressed having recently gone through a traumatic divorce. She had put back all and more of the weight she had previously lost. She was drinking excessively as well as bingeing periodically. During her previous therapy I had not enquired into her birth experience. On this occasion not only did we discover that she had a negative birth experience associated with the fact that she had been adopted, but we also located significant prenatal trauma which included an attempt by her mother to abort her very early in pregnancy. Although she was not able to describe this incident in any detail she was positive about it because of the very strong feeling of being threatened with destruction. Therapy was directed at dealing with the pain and hurt of this obviously intense rejection which had been unconsciously maintained and expressed in symptoms of depression, overeating and drinking. When she was finally able to accept this deeply rejected part of her personality she began to feel very much better and her depression left her. She also found that she no longer required to drink or eat excessively. She began to lose weight. An interesting case occurred recently during the final revisions of this paper. During hypnosis a 36-year-old woman graphically described how her efforts to enter this world were being frustratingly blocked by the saddle of the bicycle upon which her mother was riding at the time. She attributed some of her recurring feelings of helplessness and powerlessness to this experience. I have indicated elsewhere (1979, 1981) that it is my belief that the critical experience is a time when the individual becomes aware that he has incurred a profound, usually parental, disapproval. He will internalize this disapproval and attempt to gain acceptance, allotting a portion of the personality to the task of taking care of this problem. This part of the personality assumes the

separate set of feelings, thoughts and beliefs that characterize an independent ego state complex. The more dissociated that such an ego state complex becomes from the main personality the less likely it is to be accessible to psychotherapy. I am certain that an alien ego state formed in this manner during the prenatal period is the most difficult to uncover and deal with. However when this is accomplished there is an improved integration of the personality with the disappearance of the symptoms arising from former early conflicts. A husband and wife travelled some considerable distance to see me from the U.S.A. after discovering the advice given in my book "Unlock Your Mind And Be Free" to be very helpful. The husband is a scientist of repute and yet found that he was experiencing negative feelings in many unrelated situations and that he had strong feelings of inadequacy which were not commensurate with his many notable achievements. He also had some sexual inhibitions with a significant reduction of sexual activity. In hypnosis he was able to locate some very early prenatal experiences which were presumably contributing to his negativity. His case is of particular interest because, like a true scientist, he decided to pursue his hypnoanalytical studies further and bought and thoroughly read my professional book on the subject. He made the valuable criticism that greater emphasis should be placed on the role of unsuccessful abortion in creating prenatal trauma. He continued to undertake self-hypnoanalysis and was able to locate and deal with other prenatal experiences both in himself and his wife. They wrote to me detailing the tremendous improvements that they had noted in their lives. For the husband the main changes were increased feelings of confidence, a greater overall warmth of personality and a marked rise in creativity. For the wife there has been an increased ability to express her feelings especially those of anger. She has lost the sensations of suffocation that previously had periodically overcome her, was better able to relax and had noted a significant improvement in her memory and concentration. In her case there had been several prenatal experiences including an abortion attempt which required to be dealt with. Since these had been deeply buried in her unconscious memory it was good to learn that her distance from me did not preclude her from successfully pursuing therapy in her own home. Conclusion Salk (1966) has made the point that the major proportion of mental patients in hospitals have personality problems that are persistent in spite of therapy and can be regarded as irreversible. Since such problems are not amenable to treatment prevention is the only rational approach. A greater understanding of the factors acting pre- and perinatally to create these disorders will eventually enable us to reach this goal. This paper has demonstrated that not only is there increasing evidence that prenatal influences can markedly shape our destiny but that these influences can, by hypnotic techniques, be located, modified and frequently neutralized. The prevalence of these influences in cases of depression, where up to 30% are likely to be thus affected, not only explains why this illness is often so resistant to therapy but indicates a specific direction for future therapy of this and other similar conditions. It is my hope that the message being reiterated at this congress will be heard all over the world and that this paper will become only one of many to explore this exciting and largely uncharted field. Sidebar First International Congress on Pre- and Peri-Natal Psychology, Sunday July 10, 1983. References References Barnett, E.A. 'Unlock Your Mind And Be Free!', Kingston, Canada: Junica Publishing Co. Ltd., 1979. _____ 'Hypnoanalysis and the Negative Birth Experience'. Medical Hypnoanalysis, 1980, 68-74. _____ 'The Ideomotor Questioning Finger Technique: Some Problems in its Performance and Interpretation,' Medical Hypnoanalysis, 1980, 169-72. _____ Analytical Hypnotherapy: Principles and Practice, Kingston, Canada: Junica Publishing Co. Ltd., 1981. Beadle, M. 'A Child's Mind.' New York: Doubleday, 1970. Chamberlain, D.B. 'Reliability of Birth Memories: Evidence from Mother and Child Pairs in Hypnosis'. Read at 23rd Annual Scientific Meeting of the American Society of Clinical Hypnosis, Minneapolis, November, 1980. Cheek, D.B. 'Sequential Heat and Shoulder Movements Appearing With Age Regression in Hypnosis to Birth.' American Journal of Clinical Hypnosis, 1974, 16, 261-6. _____ 'Maladjustment Patterns Apparently Related to Imprinting at Birth. American Journal of Clinical Hypnosis, 1975, 18, 75-82. Cramond, W.A. 'Psychological Aspects of Uterine Dysfunction.' Lancet, 1954, 2, 1241-1245. Davids, A. and DeVault, S. 'Maternal Anxiety During Pregnancy and Childbirth Abnormalities.' Psychosomatic Medicine, 1963, 24, 464-469. Desousa, A. 'Causes of Behavior Problems in Children.' Child

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