Birth Trauma: The Psychological Effects of Obstetrical Interventions

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Full Text: This is birth. The torture of an innocent. What futility to believe that so great a cataclysm will not leave its mark. Its 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. Dr. Frederick Leboyer (Menzam, p. 30, 1975) INTRODUCTION For the past twenty-five years I have studied the process of birth and the kinds of impacts that birth has on babies. I have observed hundreds of babies being born, kept objective records of their births, and followed them for twenty years. I also interviewed medical and psychological practitioners about birth and the effects that births had in their patient populations. In this process I made many discoveries that I did not anticipate. The foremost discovery was that medical interventions appear to have long-term detrimental (physical and psychological) effects and, because of this, even the most commonly used obstetrical interventions must be questioned. I am not alone in this position. In her book, "Obstetric Myths Versus Research Realities," medical researcher Henci Goer documents that the most common obstetrical procedures of this era are routinely used when there is no research or scientific basis for their existence, nor are there sufficient indications of their safety (Goer, 1995). Thomas Verny's (1992) article on the effects of obstetrical interventions concluded, "Many high-tech tests, procedures and routines used in obstetrics have no proven efficacy and are really more in the nature of rituals than medical interventions" (p. 101). He concluded that, because of potential harmful effects of obstetrical procedures, medical interventions should be limited to medically high-risk births rather than all pregnancies and births. Obstetrical interventions often result in psychological as well as physical complications and outcomes (Emerson, 1996b; Kohen, 1983, 1991). Validity of Birth Memories Most of the information in this article is based on birth (obstetrical) memories of clients (obtained during regression therapy), and their perceptions of how obstetrical interventions affected their lives. It is important to address whether it is possible under such circumstances to collect accurate data. One measure of the validity of birth memories comes from the fact that they appear spontaneously in many different forms of treatment, even when the theoretical bases behind the treatments may not recognize their legitimacy. For example, birth memories and their associated pathologies have been reported in psychoanalysis (Rank, 1929; Feher, 1980; Fodor, 1949), hypnosis (Rochas, 1911; LeCron, 1963; Cheek, 1974), hypnotherapy (Chamberlain, 1988), primal therapy (Janov, 1970; Farrant, 1986), psycholytic therapy (Grof, 1979), body-oriented therapy (Hendricks &Hendricks, 1987; Emerson, 1993), yoga breathing (Grof, 1988), and holding therapy (Laibow, 1986, 1988). In addition, birth memories appear in dreams and nightmares (Peerbolte, 1975) and are routinely manifested in artwork and/or creative productions (Irving, 1995). Another measure of the validity of birth memories comes from clinical research on regression therapy, which shows that clients spontaneously regress to birth, whether they are invited to or not, and show improvement in symptoms as a result of these regressions. Thousands of clients have instinctively regressed and uncovered memories from early childhood, birth and, in some cases, from the prenatal period. Many have recovered memories about obstetrical interventions, traced their symptom etiologies to obstetrical procedures and, as a result, experienced resolutions of their symptoms (Emerson, 1996b). Another measure of validity comes from what is called verification research, (i.e., research that attempts to compare regressees' birth memories with objective data such as medical records, the reports of people present at the birth, and/or the memories of relatives and parents). When verified against objective records or the memories of those present at birth, birth memories are highly accurate (Chamberlain, 1988). Particularly impressive are cases where regressed adults recall, and later confirm, the use of obstetrical

interventions in spite of being told to the contrary (Emerson, 1996b). Birth Trauma Rates A number of independent measures of birth trauma have been discovered and developed, and each of these indicate that levels of birth trauma are very high. Using four separate measures of birth trauma, my colleagues and I (1995) found that 45 percent of babies experience high levels of birth trauma, and these traumas require specialized treatment. Another 50 percent of babies experience some degree of birth trauma, usually ranging from mild to moderate, and babies are usually able to adapt to mild levels of trauma, and may require little or no specialized treatment. The infant's parents are able to handle treatments, with minimal direction and supervision. It is shocking to think that so many babies are traumatized by birth, and yet the measures and the levels of symptomology indicate that they are. For example, babies have many symptoms which parents and physicians consider normal, but they are actually symptoms of underlying birth trauma. For example, the total crying time per day for babies, considered within the normal range, is about two hours (Kitzinger, 1990), and can range up to six hours. However, it is informative to know that the average crying time per day for babies with no birth trauma is 20 minutes and most of their crying is used to communicate their needs and discomforts. This is only one example of many symptoms that are considered "normal" but, in fact, reflect unresolved birth traumas. Other researchers have confirmed that birth involves a considerable risk of trauma. Dr. David Chamberlain, author of Babies Remember Birth, (1988) says that while babies experience a variety of negative and positive events during birth, "it is a rare baby who does not experience some trauma" (personal communication, 1991). Why is the incidence of birth trauma so high? There are multiple reasons that have been offered (Emerson, 1996b), but the most logical seem to be the following: * The industrialization of society and the increasing emphasis and reliance on technology. * The commensurate increases in birth-related technology. * The increases in stress in western cultures (prenatal stress has been shown to increase the incidences of birth trauma). * The increase in fetal alcohol and drug syndromes, unwanted pregnancies, and prenatal abuse (all more common in industrial than in agrarian and preliterate cultures). * Maternal prenatal traumas resurface while giving birth and affect how giving birth is perceived and experienced. When any of these factors are present, births can be experienced as traumatic, when in the absence of obstetrical interventions there are no objective reasons for traumatization. Thus it should be empahsized that prenatal traumas are one independent source of birth traumatization, and obstetrical interventions are another and that the fetal child may be traumatized by either or both circumstances. Theoretical Concepts There are a number of important theoretical concepts that make the negative effects of obstetrical interventions understandable. These concepts have been refined from years of observing interventions and their outcomes. 1. Unconscious Dynamics. Obstetrical traumas exert their effects through unconscious aspects of the psyche. Stated differently, the consequences of obstetrical interventions are mediated by unconscious (rather than conscious) aspects of the personality, by what psychologists call "the shadow." The shadow consists of thoughts, attitudes, feelings, beliefs, perceptions, and memories of which people only become aware of when some dysfunction, distress, and/or disharmony in their lives causes them to explore their inner worlds. The following case exemplifies this point. A highly successful corporate executive loved his job and was accurately perceived as energetic, friendly, and happy hy his co-workers. On the other hand, he had some powerful attitudes of which he was only dimly aware. In reference to his job, he frequently used the words, "I'm going to die if I don't get out of here." He had periodic depressive episodes, during which he felt stuck in his job and felt like he was going to die if he didn't do something different. At other times, when he was not depressed, he seemed to have no memory or recognition that he had been depressed. He started regression therapy, and was invited to examine any experience in his life that would help him to understand his depressive episodes. Even though he had never conceived of the possibility, he regressed to his birth, where he found himself jammed up against the pelvis. He couldn't go forward, couldn't retreat, felt tremendous pain in his head and had difficulty breathing. He also experienced a considerable amount of claustrophobia and intense fears of dying. Medical records confirmed that he been stuck for a long time, experienced problems getting enough oxygen, and been delivered by forceps. After

completing his regressions, he no longer felt trapped in his job (apparently having released his claustrophobic feelings), and no longer had irrational depressive episodes (apparently caused by the impotence of his birth experiences). He felt more alive in his job than ever, was happy and content to stay there, and felt no pressure to search for other work. At a long-term follow-up evaluation, these attitudinal changes appeared to be permanent. 2. Symbolic Activation. Obstetrical memories and experiences tend to be activated in life situations which are symbolically similar to birth in some way. For example, if obstetrical traumas involve progress in the birth canal, then obstetrical traumas are likely to be activated in life situations which involve progress or lack of progress. Following is a case example involving a man whose promotion (i.e., his progress) symbolically activated his birth feelings and birth memories. During most of his professional career, the man was largely asymptomatic in terms of his birth trauma until offered a promotion (the birth-symbolic event, where he had a chance to make significant progress). When offered the "promotion of his life" he turned it down, ostensibly because of high blood pressure (which developed when he was offered the promotion). The historic roots for his symptoms were not clear to him, nor would they likely be to anyone. He was willing to regress and, during his rebirthing, experienced the cord wrapped around his neck so that every move forward resulted in life-threatening losses of oxygen. This experience was the basis for his feelings of impending death (lack of oxygen) when he received the offer of a promotion (progressing down the birth canal). His body reacted to both events with increased heart rate and blood pressure. Following the regression, it was as if a miracle cure had happened. He understood the irrational basis for his high blood pressure and his fear of and was able to negotiate the promotion, which he was now eager to accept, for a later date. 3. Catharsis and Life Experiences. Clinical research has shown that when traumatic feelings are deeply experienced, they can be released through catharsis so that they are no longer "in" the organism, and the organism is freed from any trauma impacts (e.g., Goodfield, 1976). For example, one woman had been abandoned by her father when she was two. She continually created abandonment in her life by unconsciously choosing men who were characteristically abandoning and/or by (unconsciously) manipulating men to leave her. As she grieved the loss of these men in her life and received support from her family, friends, and therapist, she became somewhat healthier and began making better choices about men. However she was still symptomatic. With the help of her therapist, she regressed to her infancy and toddlerhood and uncovered experiences about the loss of her father. This re-experiencing freed her from the compulsions or needs to repeat the same abandonment scenarios over and over again. Regression therapy is one of the oldest treatment forms for psychological disorders, and a proven method for healing psychological traumatization (Emerson, 1996c). 4. Recapitulation. Recapitulation is probably the most important concept in understanding the impacts of obstetrical interventions. In Webster's (1989) dictionary, recapitulation is defined as ". . . the theory that an organism during its embryonic development passes through stages in which certain ancestral structures are repeated." However, recapitulation is not just a biological process of the embryonic period. In its psychological form, recapitulation is a process whereby people unconsciously recreate past events and traumatic experiences in their lives. They do so in an attempt to externalize traumas from the unconscious so that their traumas might be dealt with in here-and-now reality, and cathartically released from their systems. The example given earlier about the woman who unconsciously chose abandoning men is an example of recapitulation. However recapitulations do not heal traumas, they only provide opportunities for traumas to be therapeutically dealt with and, in some cases, they reduce shock levels in the body. A variety of therapeutic procedures (including catharsis, repatterning, and shock negotiations) are required to heal trauma, as are qualities of the therapeutic situation such as empathy, compassion, and safety. There are four kinds of recapitulation. A. Direct Recapitulation. Direct recapitulation, the most common kind, occurs when people unconsciously choose or manipulate life situations in order to encounter and experience their unresolved traumas. For example, one woman who had been abandoned as a baby, unconsciously recreated her abandonment trauma by first marrying a traveling salesman, who was always leaving her to go "on the road," and then marrying a merchant marine who was gone six months out of the year. She perpetually

felt abandoned and her direct recapitulations were unconscious attempts to activate catharses and thereby heal her abandonment trauma. The problem is that most direct recapitulations are unconscious, i.e., they feel like pain in the present rather than pain from the past, and people tend to feel victimized rather than liberated by their recapitulations. In addition, healing requires proper contextualization (i.e., an awareness of the regressive scenes from which recapitulations emanate) and deeper catharses than recapitulations normally allow. It is for these reasons that people should be in therapy, to bring their recapitulations into awareness and to experience their traumas within the safety and integrity of the therapeutic situation. B. Avoidant Recapitulation: Elimination Type. There are two types of avoidant recapitulation. The first is elimination-type (referred to as e-type), meaning that people manipulate or choose life situations that eliminate the possibility of encountering their unresolved traumas. I recall an abandoned twin who was an avoidant recapitulator (elimination type), choosing a life which protected her from ever experiencing her abandonment again. She was unaware that her Me style was a reflection of her early abandonment; lack of awareness is the norm. As an adult, she owned and ran her own business, so that no one could ever fire (i.e., abandon) her. In her own words, "When I am my own boss, no one can ever get rid of me". She also married a physically handicapped man, which to her meant "he will never leave me because he needs me so much." It might appear that avoidant recapitulation is a resolution of trauma, but it is not. Memories of trauma are still present in the unconscious, and these have symptomatic effects. C. Auoidant Recapitulation: Identification Type. The second kind of avoidant recapitulation is called identification type (referred to as I-type), and involves two psychological aspects. One aspect is avoidance, as previously described, and the second is projection and self empowerment. The basic dynamic behind I-type recapitulations is that people project their traumatic feelings onto others, and then identify with and act out (i.e., become) the forces which traumatized them in the first place, providing themselves with a sense of power. This means, for example, that abandoned people project their abandonment onto others, identify with their own abandoners, and act out (i.e., become abandoners) with the people they project upon. This has the effect of providing traumatized people with symbolic and actual power over the forces which traumatized them. They gain their power by identifying with and becoming the traumatizing agents, and they are thereby empowered because they can not be victimized by the forces they are identified with and are expressing. For example, one man who had been physically abused as an infant by his father chose life circumstances where he was unlikely to experience physical abuse again (by living alone and working a solitary existence as a coroner's lab technician). At the same time, he identified with his father (the traumatizing agent) and was extremely abusive with his pets in the same way that his father had been abusive with him. He routinely and savagely beat his dogs with a belt, and felt empowered by it. As he said to me, "They're just pathetic and weak, beaten down things (the projection) ... I just feel so powerful when I am hitting them ... I mean I get so high, it's hard to explain, and I am sure they must love it too, because it lets them know what they must do." His isolated life and abusive power over his dogs limited the likelihood that he would ever be abused again. D. Confrontive Recapitulation. Confrontive recapitulation means two things: 1. that people seek and find their traumatic feelings and experiences outside of themselves, in other situations and/or in other people (rather than inside themselves), and 2. that people then enact challenging, corrective, and/or confrontive attitudes and behaviors toward these other situations or people. In this process, it is quite clear that their recapitulations are quite different from those used by direct recapitulators, who attempt to locate and find their traumatic feelings within themselves, and to resolve them within the boundaries of their own body and personality. I recall an exemplary case of confrontive recapitulation. A boy had been induced at his birth, i.e., he (and his mother) had been given Pitocin to start his birth. In his therapeutic artwork as a child, he drew pictures of his birth and his Pitocin experiences. The most common image in his drawings (which represented his Pitocin experience) was a rocket blasting off from the earth into the atmosphere. In effect, he felt overly energized and propelled, in a very frightening way, by the Pitocin. As a child and as an adult, he perpetually avoided intense and activating energies. He consistently refused to do jumping jacks during elementary-school PE because they made his

heart beat faster, and asked his mother to confront the school on his behalf. He joined the anti-drug forces in high school, and while everyone else was concerned about alcohol and marijuana, he was primarily concerned about methamphetamines (uppers). As a young school administrator, he was avidly against head start programs because "they were trying to pump energy into our school systems, create heightened activity into our children, who are already hyperactive and distracted." Whereas direct recapitulation involves contacting and feeling traumatic energies, confrontive recapitulation involves attempting to do something constructive about traumatic forces. Confrontive recapitulation means that people seek out and confront, in life, the type of forces which traumatized them during birth and other developmental periods. As is true with elimination type avoidance recapitulators, confrontive recapitulators tend to be unaware of the connections between their own woundedness and their confrontations. This limits the extent to which their confrontations are healing, because awareness is vital to the healing effort but, at the same time, confrontations can and do bring about personal change in self and others. When confrontations are directed toward society, social changes are more likely as well. It should be noted that people occasionally vary in the types of recapitulations that they use, even for the same trauma. Some fluctuate between various types of recapitulations, whereas others exhibit primarily one type of recapitulation. For example, one client exhibited two types of recapitulation with respect to her forceps trauma. She usually chose men who would, in her words, "control her, dominate her, and yank her around" (direct recapitulation of the way she experienced forceps), but at other times chose men who "were weak, and whom she could dominate" (avoidant recapitulation, identification type). 5. Trauma Interaction. The concept and process of trauma interaction is very important in understanding the effects of obstetrical interventions. Trauma interaction means three things that are highly related to each other, and may even be construed as re-phrasings of each other: * Prenatal traumas (traumas which occur before birth) influence how obstetrical interventions are perceived and experienced and bring trauma energies to the birthing process. For example, an alcoholic mother ingests large amounts of alcohol during her pregnancy, and this effects how her baby experiences birth inductions. * Most obstetrical interventions are symbolically similar to many prenatal traumas, thereby activating prenatal traumas. When a baby is given drugs or is clamped with forceps, these interventions can symbolize medication-induced or mechanically-induced abortion attempts, respectively. When a baby is held back during birth, possibly to enable the doctors or family members to arrive, the experience can (and often does) symbolize the rejection of being an unwanted and unexpected prenate. * Prenatal and birth traumas interact in creating their effects, (i.e., they rely on subsequent reinforcements before they are likely to have serious effects.) When a baby is startled and shocked during birth by the sudden appearance of a drug (e.g., Pitocin) and is later subjected during breastfeeding to the drugs (i.e. nicotine) of a mother who smokes maternal smoking reinforces obstetrical (induction) trauma. These points stand by themselves, and have been repeatedly validated through clinical observation of trauma effects. There is, however, an important qualification. Obstetrical interventions can be traumatic without relying on other factors in producing their effects. Severe traumas rely less heavily on interactional factors in producing their effects, and obstetrical interventions qualify as severe traumas. Stated differently, obstetrical interventions have been found to have traumatic impacts on life even when there are no preceding and/or subsequent (reinforcing) traumas. The Psychological Impacts of Obstetrical Interventions In the ensuing discussion I will attempt to describe only the straightforward effects of each intervention, (i.e., the effects that occur without other interventions, and without interactional influences.) However such differentation is not completely possible because, for example, cesarean surgeries are never performed without anesthesia and other intercessions. Nevertheless, most of the interventions described below are sometimes done without the presence of other procedures and without interactional influences. Under consideration will be the four most common obstetrical interventions and three of their most common outcomes.* Because negative psychological impacts of obstetrical intervention are rarely (if ever) examined, all of the consequences discussed are negative in nature. This does not mean that obstetrical interventions only have negative impact. They may have positive impact, not under deliberation, as well. In discussing negative effects, the term complex is occasionally used. A

complex is a coordinated set of feelings and behaviors that weigh heavily on the person affected by them. For example, people with inferiority complexes tend to feel inferior, and their inferior feelings influence how they behave (e.g., they may be more timid, shy, etc.) Most of the following cases refer to effects of obstetrical interventions on the workplace, careers, occupations, and professions. Obstetrical interventions also have profound effects in other areas of life such as relationships, communication, sexuality, religious/spiritual beliefs, and physical health. In deciding which traumas to describe, I chose examples that were common to all interventions. This strategy eliminates many of the idiosyncratic consequences of the various interventions. It should also be noted that the aftermath of obstetrical interventions can also be discussed in psychopathological terms, (i.e., in diagnostic categories used by mental health professionals.) However, the scope of this discussion is is on dysfunctional symptoms rather than psychopathological categories and to outline symptoms understandable to both lay and professional readers. A final qualification involves confidentiality, (i.e., all cases have been modified to protect confidentiality, and all similarities to actual persons is entirely coincidental.) Anesthesia According to Shanley (1994), analgesias and/or anesthesias are administered in 80 percent of all hospital births, and almost nothing has been published about the short- and long-term psychological effects of anesthesia. Research has been published on physical effects, and some experts believe that the increasing prevalence of brain damage and/or neurological dysfunction in U.S. children (with accompanying retardation and learning disabilities) is due to the increasing usage of obstetrical procedures, especially obstetrical medication during pregnancy and birth. (Haire, 1972; Windle, 1969). In 20 years of treating anesthesia-related birth traumas, I have found anesthesia to have a number of psychological impacts, some of which are bonding deficiencies, shock syndromes, control complexes, productivity complexes, boundary complexes, self disorders, power complexes, and substance abuses. For the sake of brevity, only the first three will be described and discussed. Bonding Deficiencies. I first noticed the effects of anesthesia on bonding when, observing newborn babies in India, I noticed radical differences in the quality of bonding in certain babies. Curious, I investigated the births of all the babies I observed. I found that anesthesia-free babies, with one exception (see below), were far superior in their bonding when compared to anesthetized babies. They exhibited longer and greater instances of the qualities that indicate healthy bonding, such as eye contact, concentration on each other, depth of feeling during eye contact, and psychical contact. Indian mothers could easily anticipate when their babies were going to urinate or defecate and took their babies outside at just the right times. Indian mothers also knew when their babies dreamed, if the dreams were good or bad, and, at times, knew some of the content. Levels of mutuality were high. Mothers and babies were constantly sharing experiences together, such as laughing over a funny sound, noticing an unusual bird sound, smelling an unusual odor, being excited about a new scene and understanding of each others' communications. During the bonding period, Indian mothers could ascertain the specific meanings of their babies' cries. They could discern between cries which meant itchy skin, wet diapers, bad dreams, hunger, thirst, gastric discomfort, etc. I also found that babies demonstrated superior bonding if they were free of prenatal and/or birth traumas. In trying to understand the reasons for decreased bonding levels in babies who were anesthetized, I turned to my records on clients who were anesthetized at birth. I found that regressees reported significant losses of awareness during their anesthesia experiences. They feel drugged and "out of touch," and this influenced their desire and/or their ability to make contact with their mothers. On this basis it is presumed that high levels of awareness and alertness during the first 24 to 48 hours after birth are necessary for quality bonding to occur. My current conclusions are that depths and types of communication (and therefore bonding) occur spontaneously when there are no unresolved birth traumas, when obstetrical medications are not used, and when shock is not present. Bonding is facilitated by immediate or prompt reunions after birth, with little or no separation time. Depths and types of communication are established and imprinted during the bonding period, and that parents and their children have subsequent opportunities to engage these levels of communication throughout their lives. Various researchers, such as Ainsworth (1991) and Magid (1987), have documented the multiple and long-range effects of deficient bonding. Anesthesia

Shock. Anesthesia shock refers to three conditions. The first condition is brought about by the sudden, unexpected body and psychological changes that occur when anesthesias are administered. Stated differently, when anesthetics are administered, they come as a surprise, and they overwhelm and shock the sensory, motor, emotional, and cognitive systems of birthing babies. A related aspect of the first condition is that babies receive overdoses of anesthesias. This occurs because anesthesias are administered according to mothers' (not babies') body weights. Because the placenta acts more like a sieve than a filter (as originally thought), the babies, with much lower body weights, receive an overdose. As Janov (1983., p. 35) says,... the drug passes through the placental barrier, providing a dose several hundred times too powerful for the baby so that neither the mother nor the baby can react normally. The effects of anesthesia shock are magnified because of the fact that fat retains anesthesia, and babies' bodies are proportionally high in fat content. This means that they may retain a proportionately high level of anesthesia in their bodies, with resultant anesthesia shock, for days after birth. The physical and psychological changes that occur with anesthetics administration are described below. Anesthetized babies almost always experience the first three, and usually one or two of the others. For example, babies experience shock first, then a perceived insult to their psyches, then and then a sudden or progressive losses of awareness. The experiences are: * Startle shock: being startled, frightened, and overwhelmed by the sudden appearance of body sensations of unknown origin, and feeling out of control resulting in psychological shock * Perceived insults to the self system: I was doing fine, I could have done it on my own * Sudden or progressive losses of awareness and alertness (spacing out) * Sudden or progressive losses of energy; energy being drained; loss of vital energy to do anything * Sudden or progressive losses of orientation and direction; * Sudden or progressive losses of control and power, resulting in terror * Sudden or progressive losses of physical functioning * Sudden or progressive losses of consciousness; fear of dying; no motivation to do anything but sustain life thread; being barely conscious The second aspect of anesthesia shock has to do with the prolonged presence of anesthesias in mothers' and (to greater extent) babies' bodies, and the corresponding reduced levels of awareness, losses of control, and losses of consciousness, all of which serve to perpetuate and reinforce shock in the post birth process. The third aspect of anesthetic shock has to do with mothers' own responses to anesthesia. If and when mothers are shocked by the administration of anesthesias, either because of allergic reactions, lack of preparation, lack of permission, or just from the body changes that occur as a result of anesthesia administration, then shock is passed on to babies. In fact, whenever mothers are in shock (for whatever reason) the neurophysiology of maternal shock passes to babies through the placental interface. Following are some examples of anesthesia shock and four kinds of recapitulations. In general, direct recapitulations of anesthetic shock usually occur in life situations which involve sudden and/or unexpected changes in the environment (e.g., earthquakes, fires, storms,), sudden and/or unexpected events (e.g., car accidents, health crises, divorces, losing jobs, deaths), and sudden and/or unexpected changes in body feelings (the kind which occur during sexuality, during sports activities, etc.). If babies are startled by the sudden influx of anesthesias during labor, then they will tend to be shocked by the sudden influx of anything during life. For example, one client was shocked by the influx of anesthesia, couldn't feel separate from the anesthesia, felt terrified and out of control, progressively lost energy for his birth, and felt he was going to die. In life he experienced new relationships in the same way, i.e., he felt he was being overwhelmed by new relationships, couldn't keep himself separate from new relationships (i.e., the anesthesia), and felt that relationships always happened too quickly and made him go "unconscious", i.e., behave in unaware ways. Once in shock, he felt terrified and out of control, progressively lost energy for the relationship, and felt he was going to die. When he resolved his anesthesia trauma, he was able to stay out of shock and in relationships. I worked with one client who exhibited all of the anesthetic shock patterns, in the order described. For example, whenever his partner suddenly changed her mind (she was quite impulsive and unpredictable), he experienced anesthetic startle shock. He then felt insulted by her. He perceived her as trying to annihilate him and lost awareness, energy, and orientation (what he wanted to do and why). He lost all feeling of control or power and, on occasion, (if she

had enough changes of mind or perspective) he fainted (i.e., he lost consciousness). His anesthesia traumas were severe and, after being treated for them, those situations rarely elicited anything more than a sense of surprise and curiosity when his partner changed her mind or asserted herself. People employing avoidant recapitulation (elimination type) generally seek to avoid sudden or unexpected changes altogether, unconsciously fearing loss of awareness, loss of control, and the other experiences associated with anesthesia shock. Because of this, they often exhibit tenacity about being aware, anticipating possible changes or problems before they occur, being properly oriented, keeping energy levels intact, etc. They also tend to be aversive about anything that could change their "internal body environment" (such as alcohol, drugs, foreign foods, bacteria, viruses, etc.), particularly substances that have effects like anesthesias (e.g., that are tranquilizing or de-energizing). An example is a laboratory scientist who controlled variables so that nothing was ever unexpected. He introduced changes one at a time and even hypothesized alternate outcomes so if experiments took another turn, even that was expected. He lived his life according to a strict schedule, and ate only foods that did not effect his sensitive system. People who avoidantly recapitulate (identification type) tend to inflict their anesthetic shock onto others. A good example is a military sergeant who made others numb with fear. He re-enacted the anesthetic he experienced at birth by using his personality to inflict an anesthetic-like shock on others, all outside of himself. People who confrontively recapitulate typically confront the forces which traumatized them. I recall a nurse who exhibited this type of recapitulation. She was anesthetized during birth and lost consciousness. As an adult, she was an avid teacher of consciousness-raising techniques, teaching her students to remain aware during life's most stressful and difficult moments. She also promoted drug free births and taught medical personnel to be in touch with their vital energies, so that they would be able to avoid medical burnout, which she defined as being numb, out of touch, and unfeeling when treating patients in medical situations. Invasion I Control Complex. It is not uncommon for anesthetized people to experience two or three of the negative effects of anesthesia with considerable intensity but only occasionally do people experience all features at high levels of (traumatic) intensity. In general, however, the greater the number of features, the greater the degree of traumatization. Each of these features is part of what is called the Invasion/Control Complex because feeling invaded, taken over, and controlled are the basic outcomes of anesthesia usage (except when lesser dosages or mild analgesias are used, in which case there are greater tendencies to experience the lesser-traumatizing features such as interruptions, perceived insults, and/or interferences). It should also be noted that when babies are in serious trouble, the most traumatizing features are ameliorated to a degree (this is true for all obstetrical interventions). In such cases, babies tend to feel helped, rescued and/ or saved, rather than intruded upon, invaded, and controlled (although these do remain as unconscious impressions, but at less intense and destructive levels). In addition, each of the features in the interruption-control chain can be separately recapitulated. For example, one person felt traumatically interrupted, then interfered with, then invaded, and finally felt totally controlled by the cesarean procedures. In life, he directly recapitulated the interference trauma with his wife, the interruption trauma with his secretary, the invasion trauma with cigarette smoking, and the control trauma with substance abuse. In general, when people directly recapitulate anesthesia experiences, they sometimes involve themselves in various substance abuses, particularly ones which engender the same effects as the anesthesias they were administered during birth. For example, one client regressed to birth and found that his mother had been given Pitocin (which he experienced as pushing and activating) to augment his birth and inhalation anesthesia to reduce pain (which he experienced as loss of consciousness). His substance abuses followed the same exact pattern. He first took uppers (which activated him) and then drank large amounts of whisky until he fell asleep (i.e., lost consciousness), so his substance abuse patterns directly reflected and recapitulated his anesthesia experiences (traumas). I would like to reiterate that substance abuses are caused by an interaction of traumas and other life experiences. This means that substance abuses have multiple causes, and all causes must be taken into account and treated during the therapeutic process. The case just described is an excellent example. His treatment for substance

abuse was inconsequential and ineffective until his birth regressions (where he discovered the Pitocin and anesthesia as major foundations for his substance abuse). However, his recovery would not have been complete without dealing with some childhood experiences and without the support of Alcoholics Anonymous. The experience of being totally taken over and controlled may be directly recapitulated by people who (unconsciously) choose to be in relationships where they are controlled, only to experience the (shadow) aspects of their anesthetization traumas (e.g., anxiety, powerlessness, resentment, anger, and desire to fight back and/or escape). In some cases the direct recapitulation of control involves drugs and, in some cases, it does not. In an example of the former, a woman was totally controlled by drugs that were given and/or administered by her husband, who used them to control her. At the same time her husband was avoidantly recapitulating (i-type) because he was the instigator of control through drugs, but did not use drugs himself. Control can be avoidantly recapitulated by people who avoid any contact with situations which involve external control. People who live in alternative communities, choose to live without external structure and rules, participate in rebellious gangs or groups, and are self employed are examples of people who avoidantly recapitulate (e-type). On the other hand, people who fight control or drugs are examples of confrontive recapitulators. Invasion/Control complexes are commonly recapitulated in others ways as well. For example, avoidant recapitulators (etype) are people who are likely to stay adamantly free of recreational drugs and, sometimes, free of situations which involve approved drugs (such as food additives and prescribed medications). I have worked with many clients who choose health foods because they do not contain drugs and other additives. Other clients participate in alternative medicine because they are (unconsciously) avoiding contact with drugs at any level. I am often asked whether e-type recapitulation is a self-healing process, and the answer is a qualified "yes." Some degree of healing occurs because people are developing and/or exercising power over (symbolic) forces which traumatized them, and this is particularly valuable for reducing shock levels in the body. However many other aspects of trauma remain untreated. It should be added that all the main features of a person's anesthetization trauma can be (and are) recapitulated. For example, if control is the main feature, control is the feature most likely to be recapitulated and, if invasion and control are the main features, they are both likely to be recapitulated. Inductions and Augmentations Inductions refer to administrations of drugs (commonly Oxytocin or Pitocin) or when the amniotic sac is purposefully or spontaneously ruptured in order to start labor. Inductions are usually performed when labor does not spontaneously begin within two weeks of the due date (although physicians vary widely in the amount of time that they "allow" before inducing). Augmentations refer to administrations of labor-inducing drugs after labor has started, in order to speed up and/or intensify contractions. According to medical researcher Shanley (1994), between 20 and 40 percent of all hospital births involve the use of drugs such as Pitocin or Oxytocin. Inductions and augmentations have a number of effects, some of which are bonding deficiencies, induction/augmentation shock, invasion-control complexes, productivity complexes, substance abuses, boundary complexes, rescue complexes, pain complexes, and self-esteem issues. Only the first three will be described. Bonding Deficiencies. When children or adults are regressed to their inductions and/or augmentations, they report feeling shocked, invaded, intruded upon, interrupted, interfered with, and overwhelmed with drugs which increase pain, increase anxiety, and dimmish control (among other effects). In order to bond, babies need to be perceived and reflected accurately. Parents need to understand and acknowledge the physical pains, anxieties, intrusions, losses of control, etc. that induced babies experience. Because most medical personnel and/or parents do not understand that babies are conscious during birth and that their traumatic experiences need to be perceived and acknowledged, babies are not able to bond. In fact, babies are no different than adults in this regard. For example, when spouses die, it is obvious that their surviving partners need to experience their losses and griefs, and receive understanding and acknowledgment from others who can reflect their pain and suffering. Commensurately, deep bonds of appreciation and gratitude form between those who support and those who are grieving, and these bonds often continue in life-long relationships. The situation with newborn babies is no different. Traumatized babies carry

induction and augmentation traumas into the bonding period and need their parents to understand and acknowledge their struggles and pains. When parents or caretakers mirror babies' pain and struggles, healing occurs and life-long bonds are established. When this is not done, bonding is inhibited. Babies do not feel seen and/or heard when their vital pain is not recognized and acknowledged. This lack of acknowledgment acts as a wedge in relationships between parents and babies. Induction/augmentation Shock. During inductions and augmentations, mothers report that they frequently experience (but don't mention at the time) sudden, frightening, and extreme changes in body feelings. They generally feel more pain, greater frequency and intensity of contractions and more physical discomfort. Babies feel the same changes, but in proportions much greater than their mothers. Psychological shock is sometimes the result. In addition, induction and augmentation shock have the same general etiology as anesthesia shock. Babies are psychologically shocked by the sudden appearance of body changes brought on by Pitocin (or similar drugs) and feel totally out of control. Their shock is exacerbated by the "overdose" level of administered drugs. Induction/augmentation shock has some of the same features as anesthesia shock. In particular, the first features (1. startle shock; 2. perceived insult; and 3. perceived annihilation) are identical, but the remaining features are different. In general, Pitocin is experienced as an activating, energizing force that compels and pushes, and anesthesia is experienced as a force that minimizes and lessens awareness and functioning. Note that the features listed below are directly related to the degree of trauma and shock (i.e., the most intense level of trauma), with early features more characteristic of trauma and later features more characteristic of shock. The features are: * Surge of adrenaline and urgency (sudden or progressive). * Feelings of resentment, anti-authoritarian feelings, betrayal, and rage (sudden or progressive). * Increase in decisions which are hurried, dysfunctional, or lacking in personal integrity (sudden or progressive). * Higher risk of birth complications (especially dystocias, dysfunctional lies, asynclitisms) which result from the previous example. * Loss of control and power, resulting in terror (sudden or progressive). * Loss of physical functioning (sudden or progressive). * Abject terror (sudden or progressive). As with other effects, all these features can be recapitulated in various ways. For example, one client's induction shock was triggered every time her boss gave her an order (i.e., forced her to start something she didn't want to start), and she was directly recapitulating in this way. Another client manifested avoidant recapitulation (e-type) by avoiding making decisions. In almost all cases, clients have additional life conditions which reinforce and deepen the recapitulated traumas. Invasion-Control Complex. Researchers have found that babies, if they are not interrupted, initiate the birth process through their own endocrine system. In addition, there is a natural rhythm to the initiation and pacing of the birthing process, much of it organized by the biology of babies. Conversely, inductions and augmentations interrupt the natural rhythms, timings, and pacings of the birth process and interfere with "who is in charge." When babies' natural rhythms are altered by drugs, they initially feel shocked, confused and frightened. They subsequently feel (in increasing order of traumatization) interrupted, interfered with, intruded upon, invaded, and/or controlled. As indicated earlier, most people experience several of these features, and some people experience all. Following are some examples of induction and augmentation recapitulations. Direct Recapitulation. When people directly recapitulate, they tend to perceive situations as involving the features described above, even when the actual situations are unlike their experience. They also tend to (unconsciously) anticipate interruption, interference, intrusion, invasion, and/or control in their lives. They feel distracted by their anticipations and make life decisions (usually unfortunate and dysfunctional) based on their anticipations. In some cases, they unconsciously choose life situations in which these features are common, or manipulate situations so the features occur. I recall a school principal who was a direct recapitulator of his induction experiences. As a school principal, he felt like his life was "one big interruption. He said: "I get to school early in the morning (i.e., before birth starts) and things are nice. I can do what feels right. Then everyone (i.e., the Pitocin) comes in and I feel totally taken over, like my life is not my own. My whole body gets taken over, it gets quivery and shaky (the effects of Pitocin on the body). It feels like I am on a coffee high, like I've drunk three quarts of coffee (which is what Pitocin can feel like). I feel like there

are huge pressures (i.e. contractions) on me (the result of Pitocin), and I'm being shoved and pushed in directions I don't want to go (he ended up transverse, i.e., went the wrong direction in his birth)." When regressed, he experienced the Pitocin in his body, and said, "My god, this is how I feel at my desk when everyone starts coming in." When he resolved his induction experiences regressively, he no longer anticipated interruptions nor did he feel interrupted (even when he was). In addition, he was able to create some boundaries which protected him from interruptions and enabled him to work for long periods of time with high degrees of concentration, which in turn allowed him to become the innovative educational leader he had always desired to become. Avoidant Recapitulation (e-type). A woman came for treatment because of job-related anxiety. She spontaneously regressed to her birth, where she experienced the Pitocin as intensely invasive and anxiety provoking, and realized that her choice of a career (watching and maintaining an isolated lighthouse on the east coast) was a reflection of her desire to never experience invasion again. She said, "Gosh, that's exactly why I chose to be a national park ranger, and why I chose the lighthouse duty. I'm alone 99% of the time, and there are never any interruptions. I do just what I want, and follow the flow. And part of my job is to watch for invasion of foreign fishing vessels into territorial waters, and stop it right there. I just love that part the best (laughing)." Avoidant Recapitulation (i-type). I consulted with a man whose entire life was organized around identification type recapitulations. During his birth, he experienced the bliss of being in his mother and beginning a long journey to the world, and was just about to start pushing when he was "hit with a blanket of cold water" (the effect of the Pitocin). He felt deeply betrayed by life and his mother (for allowing the Pitocin) and deeply interfered with. Through his regressions, he came to understand that he was constantly interrupting others as he had been traumatically interrupted during his birth. His job was to inspect cars as they proceeded down an assembly Une. He unconsciously interceded at inappropriate times to the point that he was actually interfering. For example, one evaluation inserted in his employment file by an assembly-line worker said, "He knows his stuff, but he interferes, he sticks his butt in where his head should be." Coworkers also said they felt he "had thrown cold water" on their work. Even though he had been confronted, his interference did not change until he experienced his induction trauma and developed some insights into its implications. Confrontative Recapitulation. A man came to me for treatment because he was exhausted with his work and needed stress reduction. He was aware that his job had something to do with his birth induction but could not articulate what the connection might be. As he received treatment, it became clear. He managed and supervised the service department for a major utility company where his main job was to ensure that there were no weather-related interruptions in electrical service to more than two million customers. He did it with a passion and a zeal that was unheard of in his profession. He was often heard to say, "My customers are my babies and they aren't going to be interrupted." He spent his entire career confronting and fighting interruptions, so they would no longer occur. When he regressed, he discovered the basis for these feelings in his birth inductions and, after catharting and releasing his traumatic feelings, he said, "It's like someone drained all the drive and anxiety out of me about it, and now I can just do my work and enjoy it." Another aspect to control dynamics involves the formation of belief systems about control. When people are exposed to both inductions and augmentations, drugs are in control of starting and sustaining birth contractions, and people form very deep belief systems about lack of control. They believe that others, not themselves, are in control and that they are impotent to change how life is set up and run. This sets up a pattern of passivity which involves looking to others for advice, difficulties in taking responsibility, and tendencies toward passive aggression. Control complexes may be avoidantly recapitulated by choosing people or life situations that are entirely free of control issues (i.e., permissive and lacking in control or power) and avoidantly recapitulated (i-type) by taking control of others so that others cannot control oneself. Instrument Deliveries From a psychological perspective, forceps and vacuum extraction deliveries have similar effects, although there are a few distinct differences. For this reason, and because the majority of data on instrument deliveries comes from cases involving forceps deliveries, the term forceps (rather than vacuum extraction) will be used throughout the following discussion, and the effects

ascribed to forceps can be assumed to apply to vacuum extractions as well. Forceps deliveries have many impacts, some of which are forceps shock, bonding deficiencies, control complexes, productivity complexes, authoritarian complexes, directional confusions, pain complexes, and rescue complexes. Only the first three will be discussed. Bonding Deficiencies. Bonding deficiencies among forceps deliveries are caused by one of the same dynamics mentioned under previous interventions, i.e., an absence of trauma acknowledgment on the part of medical personnel and/or parents. When unresolved traumas are not acknowledged, subtle wedges of misunderstanding form between babies and parents, and babies feel unseen, unheard, and misunderstood. In addition, bonding deficiencies are exacerbated because forceps represent babies' first human touch, and the touching is usually objective and painful. This appears to be true even when anesthesias are used (which is normal in a forceps birth). Forceps-delivered regressees consistently report feeling crushing pains in their heads (this is less true for vacuum extraction deliveries) and this pain often becomes symptomatic in adult life. Apparently the painful levels of forceps' compression are so great that they override the numbing effects of anesthesias. When adults and children regress to the trauma of their forceps deliveries, they report feeling pain, intrusion, violence, coldness, objectivity, fear, invasion, interruption, and loss of control, among other experiences. Because of this, forceps-delivered people are often defensive to touch. This tactile defensiveness includes tension and anxieties about and/or resistances to being touched, stroked, cuddled, and/or held. Tactile defensiveness is a major outcome of forceps usage, and seriously inhibits the bonding process. A major factor in bonding is relaxed and contactful holding, hugging, and eye contact between babies and their parents, and tactile defensiveness interrupts and/or prevents all of these. However, some mothers have reported successes making eye contact while eliminating physical contact with their tactile-defensive babies. Tactile defensiveness is a basic form of avoidant recapitulation (e-type), i.e., an avoidance of touch-induced (i.e., forceps) trauma. For example, one forceps-delivered man reported that he avoided sexuality at all costs, and only engaged in sexuality "when his horns outgrew his head (i.e., his rationality)." If and when he engaged in sexuality, he did so with the least amount of touching (a situation his lovers often complained about). When directly recapitulated, forceps-deliveries can result in unconscious recreations of forceps pain, i.e., in masochistic behaviors, masochistic sexuality, proneness to accidents, and susceptibility to physical abuse. For example, one man was unable to experience sexual pleasure unless he was stroked coldly and painfully, and he traced this to his forceps birth. When avoidantly recapitulated (i-type), forceps deliveries can result in sadistic behaviors, since recapitulators identify with the traumatic sources (i.e., painful and/or traumatic touching) and act this out on other people. When confrontively recapitulated, forceps deliveries can result in people who are active in fighting pain, abuse, and other physical conditions which are symbolic of forceps births. It can also result in the choice of poor business or marital partners, i.e., in the choice of partners who exhibit unresolved forceps dynamics. For example, they may choose partners who are "crushing and cold" in their expressions of anger, or are "cold and manipulative" in the way they support. Forceps Shock. Whereas induction and augmentation shock are caused by the sudden appearance of drugs in the system, forceps and vacuum extraction shock are caused by the sudden appearance of metal or plasticized rubber on the cranium, and by the sudden and painful pressures created externally on the cranium (and, subsequently, internally). Many adults experience the shock of their instrument deliveries when they are regressed to birth and describe the resultant effects on their lives. Basically, forceps shock tends to recur in situations which are stressful, involve important transitions, and/or involve authority and control. For example, one (forceps delivered) executive went into shock whenever her boss (the authority) entered her office. She felt trapped in her office (womb), felt she couldn't move, and sometimes felt pinpoint pressures on her head (the forceps) with associated headaches. She was terrified her boss was going to nullify what she was doing (i.e., doing the birth in her own way) and make her do it differently (i.e., the forceps way). We measured adrenaline and cortisol (stress hormone) levels when the boss came into her office, and found that she consistently went into shock. When this happened, she lost personal power, couldn't think or function as clearly, and made more mistakes (which heightened her sense of vulnerability and fear). When

forceps shock is directly recapitulated, people tend to choose or manipulate life situations manifesting external control. The case just cited is an example. When people avoidantly recapitulate, they tend to avoid all situations which are authoritative, highly structured, and/or involve power and control. When they avoid, they are prone to exhibiting parasympathetic shock and being symptomatic in other ways as well. This is because avoidance (and confrontation) leaves the core of forceps traumas unresolved, and the irresolution is expressed in related symptoms. For example, one woman's headaches, another man's ulcers, and an elderly man's phobia of tall buildings (i.e., "powerful structures which can crash in on the head") were avoidant recapitulations of forceps traumas. Invasion-Control Complex. As with other interventions, it is important to know whether forceps were administered because of real emergencies or needs (a situation referred to as 'rescue forceps') or when, in fact, there was no need (called intrusion or control forceps). The name comes from the ways that forceps are experienced, and experiences form the bases for recapitulations. For example, when forceps are not needed, there is a strong tendency among regressees to experience forceps as either interrupting, interfering, invading and/or controlling, and invasion and control are then recapitulated. However, when babies are in trouble and forceps are direly needed, the experiences of interruption, interference, invasion and control are greatly ameliorated and regressees report feeling facilitated, helped, and/or rescued. In such cases, crises (i.e., birth complications) and rescue are recapitulated. (Keep in mind, however, that these forceps applications are not without some feelings of shock, intrusion, loss of control, etc.) As indicated above, forceps traumatizations are recapitulated according to the four types, and all features of the invasion-control complex can be recapitulated. Direct recapitulation of invasion-control complexes are illustrated when people recreate forceps traumas in their lives. One woman always came home with headaches, feeling that her bosses "clamped down too hard" on her when she made mistakes. She felt they were trying to interfere with how she wanted to do things. When I talked to her bosses, they indicated just the opposite that she had to be treated with kid gloves all the time, could hardly handle any feedback, and made consistent mistakes (i.e., the unconscious manipulation to bring about forceps). When she regressed to birth, she discovered that she had made many mistakes in approaching the pelvis, which caused her much head pain, and led to the need for forceps. As she resolved the forceps trauma, her mistakes spontaneously subsided, she np longer felt "clamped on" or interfered with, and became much more amenable to supervision. Avoidant recapitulation (e-type) of invasion-control forceps is evident in people who have very permissive relationships or who live in highly permissive environments with almost no authority or rules (such as some alternative communities). My interviews with and comparisons of people in both types of communities overwhelmingly support this view. I recall an alternative community resident whose ear was misshapen by what he termed a "birth injury." He was not conscious of any other aspects of his birth that might have been traumatic and did not know what caused the misshapen ear. We reviewed his medical records and found he had been delivered by forceps and that three placements had been made (meaning that the position of the forceps had been changed three times in an attempt to pull him out of the birth canal). It was interesting that he viewed the world as a cold and hard place (forceps are cold and hard) and as a "place that can grab you and pull you right down" (which is how he was pulled out). He abhorred "heavy-metal' music (forceps are made out of heavy metal) and did not trust the world because it was "always changing its ways (i.e., forceps placements)" and "causing chaos to happen." (A situation requiring forceps to be repositioned three times is probably full of chaos for both birthing babies and birthing personnel). When he resolved his forceps traumas, his world views and attitudes toward intrusiveness changed spontaneously and radically. Avoidant recapitulation (elimination type) is illustrated by a man who built and moved into a fortress, as he called it. His suburban home was equipped with movement detectors inside and out, locked gates, professional security backups, moats, guard dogs, and weapons. He had been obsessed with self-protection his whole life, but never understood why. When he regressed, he spontaneously experienced his forceps delivery, with its attendant "intrusions, boundary violations, and manipulations" (his words). He felt the forceps had pulled him the wrong way, injured his neck, crushed his head, and put him into respiratory distress after birth. (Medial records confirmed the injuries and

respiratory distress.) He finally understood his obsession for the first time and was free from the compulsive need to avoidantly recapitulate. Confrontive recapitulation of invasion-control forceps (control dynamic). People who confrontively recapitulate forceps trauma are often referred to as having authoritarian complexes or being stubborn, rebellious, angry, or unbending. People who live in "counter-cultures" that challenge and question accepted ways of doing things represent confrontative recapitulation, along with those who question and/or challenge authority in their everyday lives. I recall a forceps-delivered friend who, in his regressions, felt deeply controlled by forceps and by the medical establishment and, in his life, confronted control at every level of his existence with every level of his being. The university he attended was attempting to add regulations about music and sound levels in the Student Union (a building for students) and he reacted strongly. He organized students, faculty and alumni around the theme that "the University is trying to control our lives, dictate how we spend our leisure time, deprive us of our free movements." In this language, he was clearly describing the control imposed on him by the forceps at birth. His confrontations were successful, and the choice of music and levels was left in the hands of the student government. In this case, as is true with confrontive recapitulations, confrontations can bring about positive changes in institutions and society. Cesarean Surgery Cesarean deliveries are the number one major surgery in the United States, where the cesarean rate has gone from two to three percent (in the 1970s) to 25 percent in the 1990s (with some hospitals reporting rates of 50 percent). Experts in the field (Kohen, 1983, 1991) indicate that cesarean rates have increased, not because birth complications have increased, but because of electronic fetal monitoring (which yields spurious and unfounded estimates of fetal distress, leading to unnecessary cesarean deliveries) and because of dramatic increases in law suits against obstetricians. Legal experts contend that cesarean surgeries protect doctors because they can then be said to have "done everything they could to save the baby." Considering the rapid rise in cesarean deliveries, it is prudent to evaluate the potential effects of cesarean surgeries on current and future generations of children. It should be added that the effects of cesarean surgeries cannot be predicted without a knowledge of other interventions that accompany cesarean deliveries (such as fetal monitoring and epidurals), or without knowledge of interacting traumas. It should also be qualified that cesarean sections are of two types: planned and unplanned. Unplanned cesareans tend to involve more distress and trauma because they are more likely to involve (presumed or real) birth complications and the distresses that are associated with birth complications and/or changes in plans. Clinical research indicates that cesarean birthing has undesirable impacts. Cesarean deliveries can result in immediate symptomatic effects in babies such as nocturnal awakening, extensive crying, trauma crying (a kind of crying fueled by birth trauma), feeding difficulties, digestive difficulties, colic, tactile defensiveness, and bonding deficiencies. There are also long-term symptomatic effects such as bonding deficiencies, chronic shock, and invasion-control complexes (described below). There are other long-term effects as well, some of which are rescue complexes, inferiority complexes, guilt complexes, poor self esteem, task dysfunctionalities, boundary difficulties, and other dysfunctional behaviors and feelings. These are reported in Emerson (1996b). Bonding Deficiencies. Bonding deficiencies in cesarean babies have two sources, and both have been previously described. One source is unacknowledged trauma, and the other is tactile defensiveness. During cesarean surgeries, touch is often cold, objective, hurried, and/or painful. The touching that occurs is often associated with the anxieties of surgery, apprehension about outcomes, objectivity (touch by medical personnel is much more objective and impersonal than the touch of parents), and/or physical pain (disengagement from the pelvis and lifting from the uterus have been reported as painful by regressed adults). Time and urgency are paramount, and seldom is touching done with respect for babies' boundaries or feelings. Cesarean babies are also subject to lengthier postnatal examinations (since they and their mothers are "surgical patients") and these exams frequently involve painful contacts (shots and tests). Tactile defensiveness is the result, and becomes part of what is called the "shadow" (unconscious aspects) of cesarean-born people. Babies carry this shadow aspect into their bonding periods, with unfortunate results. The result is deficient bonding that carries into childhood and adulthood. Children (and adults) may have conscious attitudes that they

are affectionate, when in fact they are defensive to touch. Such children may subtly withdraw from or visibly defend against touching and hugging. One parent described her toddler's reaction to touch in the following way, "Whenever she is picked up, her whole body jumps, her arms flail, her arms and legs stiffen, and she remains stiff while we hold her, at least for a while. This hasn't changed much." Avoidant Recapitulation (e-type): Tactile Defensiveness. When physical pain is involved, regardless of the type of intervention, there is a strong tendency for people to avoidantly recapitulate (e-type), most commonly with tactile defensiveness. Some children totally withdraw from touching and hugging, while others allow some touching and hugging but experience anxiety when they do so. Tactile defensiveness can also effect intimacy and relationships in adulthood, particularly sexual or sensual contact because such contacts activate unconscious memories of traumatic touch during cesarean deliveries. For example, one husband reported that his cesarean-born wife had never allowed him to really hug her. He reports, "I hold her, but she is very stiff and never really lets me in." Through a body worker, he later discovered that she had a layer of physical tension on the body surface, but only when she was held. He also said, "She is very fussy about being touched or hugged; it always takes some care. And even when we hug I feel like she is not really there, like there is a thin veil between us." I-Type Avoidance Recapitulations: The Pain-Making Agent. I have treated numerous athletes (like football players who love to create pain in others) and individuals with sadistic sexual dysfunctions, whose sadistic behaviors were clearly associated with their experiences during cesarean birthing. People also exhibit direct recapitulations of their tactile experiences during cesarean births, i.e., they recreate the physical intrusions and pains associated with their deliveries. Many (self-inflicted) sports injuries and masochistic forms of sexuality are direct recapitulations of cesarean pain. While cesarean deliveries promote tactile defensiveness and deficient bonding, it is also true that they promote the opposite, i.e., the need to be touched and to bond deeply. All babies need to be touched and held, but tactile defensiveness prevents such contacts, and needs for touching remain largely unmet until traumas are resolved. Cesarean Shock. As indicated in earlier discussions, shock has much to do with sudden, unexpected, and frightening intrusions or changes, particular those involving loss of control. Recent research (e.g., Castellino, 1996) indicates that the average length of cesarean births, from the time that all incisions are complete to the time that babies are completely born, averages less than one minute. This is too quick a transition for babies, one that they are not normally alerted to nor prepared for. However, shock is not only caused by the quickness of the transition. During cesarean surgeries, the personal spaces of babies (i.e., their wombs) are entirely invaded by birthing personnel, and their bodies confronted by urgent and forceful hands (babies are slippery and need to be held firmly if they are to be lifted so quickly), rather than the loving and welcoming hands that they need. Babies are rapidly disengaged from pelvises (often requiring force), rotated, and lifted out of their uteruses. Psychological shock is the result. Shock manifests in startle and fear responses, and cesarean parents tell me that their babies frequently startle whenever they move (or are moved) suddenly or unexpectedly, or when there are sudden or unexpected noises or changes. Shock also results in tactile defensiveness, and parents commonly report that their babies stiffen and/or contract when they are initially touched. Shock also results in low Apgar scores which are slow to adapt, often taking three to ten minutes before they register in normal ranges. As indicated earlier, shock also manifests in deficient bonding and makes it much more difficult for babies to adapt to their new life circumstances. When shock is recapitulated, it manifests neurophysiologically in elevated stress hormone levels (especially DHEA, adrenaline, and other corticosteroids), and these stress hormones coincide with the recapitulated events. So, for example, in a case of direct recapitulation (described earlier), a woman executive directly recapitulated her cesarean birth by unconsciously manipulating her boss. She consistently left important details out of last-minute reports. As a result of her omission, her boss would abruptly enter her office and take her to the consulting room where she could correct her mistakes. When he entered her office, she went into shock (which we confirmed through medical tests) and experienced many aspects of her cesarean traumas although in a moderated and controlled way, replete with symptoms such as dizziness, ear ringing, fear, and sadness. Shock can occur as just

described (i.e., it accompanies and is an integral part of the traumas from which it originates) or it can be activated by situations which are symbolically or actually similar to the traumatizing scenes. So, for example, in the case of the executive above, she often went into shock when riding in an elevator, particularly when people got on quite suddenly (the elevator symbolically represented the uterus, and the passengers represented the doctors who reached in and pulled her out). In fact, being reached for frequently activates cesarean shock. For example, one client went into shock whenever her husband tried to reach her in any intense way (which triggered the reaching that occurred during her cesarean surgery). Another client went into shock whenever she felt uplifted (paralleling the lifting from the uterus during cesarean surgery). All of the preceding examples reflect direct recapitulations. Avoidantly Recapitulated Cesarean Shock. When shock is avoidantly recapitulated, two distinctly different processes occur: * Unconscious perceptions are vigilantly directed toward avoiding any situations which might activate cesarean traumas. * The parasympathetic nervous system is highly active, intricately balancing out any shock that might potentially be activated (vigilant watching activates shock levels, albeit at low levels). These experiences results in what is called the parasympathetic shock syndrome. When shock involves i-type avoidant recapitulations, people become shocking in their behaviors, in an attempt to create shock in others and thereby avoid the shock process themselves. The case shared earlier about the military sergeant is a good example. He basically shocked his subordinates with abusive words and, because he was in power, was quite safe from retaliation. When shock involves confrontive recapitulation, people tend to choose relationships with others who are in shock, and then to confront shock in others in a variety of ways. They may try to change shock (e.g., by teaching stress reduction techniques), use shock (e.g., corporate executive often teach managers to use shock to enhance competitiveness), correct shock through cognitive therapy (i.e., override shock with positive affirmations), etc. Direct Recapitulation of Cesarean Shock. An artist appeared for a regression seminar, wanting to understand why he became so anxious when painting. He said that he had to stop painting in the early hours of the morning, usually his favorite time to create, because he always became agitated and anxious. He could not concentrate and did not understand why. He was referred to a physician who, after conducting some neurophysiological tests, concurred that he was "experiencing shock" while in his painting studio and, specifically, was having spurious increases in corticosteroids and adrenaline levels as well as some of the common signs of shock (cold extremities, whitening of skin, nausea, disorientation, and some amnesia). Regression therapy was initiated, and he was invited to regress to any life situation from his past that would help him understand and resolve his anxiety. He regressed to his cesarean birth, where he was in utero in the early hours of the morning, and absolutely nothing was happening. "It was still and quiet, just the hum of the car engine," he said. Within an hour, his mother was on a surgical table and, in his words, "the quietness of my moment, my birth, was shattered with the ringing and insidious voices of humanity, the piercing shock of daylight, and the insidious insults to my body and soul." He discovered that his painting hours were a re-creation of his time in the womb, prior to birth, where he had felt "at one with the mood of the universe herself, the creative pursestrings of the Almighty." After the catharsis of recapitulating his cesarean experience and having been treated for cesarean shock, his anxieties dissipated and he was able to paint during his chosen early morning hours without "insidious anxiety and shock." Invasion I Control Complex. During birth, cesarean babies tend to experience all the features of the invasion-control complex, described above. They do so in response to the sudden appearance of hands, forceps, cold air, and physical manipulations. Cesarean babies have to be dislodged, rotated, lifted, suctioned, examined, and tested (all in a short period of time). It is not uncommon for cesarean born people to experience three or more of the listed features. Direct Recapitulation of Interruption and Invasion. A middle aged man came for treatment because he wanted his wife to stop being so intrusive. Upon further exploration, it was determined that whenever his wife tried to help him with his accounting, no matter how politely or considerately she approached him, he became insulted and, at times furious, claiming that she was interrupting him and making his progress worse (forceps were used during his cesarean birth, very near the end, and he felt they were impeding him from "doing his

job"). Another aspect of his cesarean birth was recapitulated at work. Whenever his boss walked into his office, he became highly anxious and claustrophobic, feeling that he was being totally invaded and that there was no place "he could hide." This is a common experience among cesarean-born people, and an apt metaphor for what actually happens during cesarean births, i.e., babies are invaded and have no place to go (claustrophobia) and no place to hide. His regressions surprised him because he had no idea he was a cesarean birth, nor did he realize he could remember such distant memories. Recapitulations of Interference (The Interruption Syndrome). When cesarean children are regressed to their births, almost all report feeling interrupted by cesarean procedures (resulting in what is termed the interruption syndrome). The interruption syndrome is a function of all the recapitulation types except confrontive. When directly recapitulating, children are especially vulnerable to perceiving interruptions, even when there are none. In other cases, they are adept at choosing situations which involve interruptions, or at manipulating interruptions. In all of these scenarios, their birth feelings arise. Avoidance recapitulations of interference (both types) are particularly disturbing because children will avoid or quit tasks because they (unconsciously) fear they will be interrupted (so, in effect, they avoid tasks by interrupting themselves). For example, one child had a "habit" of stopping his math work about a third of the way through and refusing to go further. It was no coincidence that cesarean procedures interfered during the first third of his birth and he hated interference, stopping before he had to encounter any. Another child exhibited confrontive recapitulation by challenging interruptions of all kinds. She regularly kept a record of all the kids who interrupted each other in class, was instrumental in having intercom systems eliminated because they consistently went off during class and interrupted classes, and had computer electronic mail (e-mail) introduced into each classroom (because of its non-invasiveness). Avoidant (e-type) Recapitulation of Intrusion. I recall another child who was avoidantly recapitulating (e-type) his cesarean birth. As is true for all cesarean children, he was birthed by someone from above who reached down and pulled him out. He could not stand to have his teacher stand above him, feeling that she was going to intrude, in his words, "She is going to gumble me." Gumble is a slang-word unique to his school describing what happens after a football fumble, i.e., everyone piles in on (i.e., gumbles) you, grabbing to get the fumbled football back, and this is called "gumbling the fumbling." This created serious problems with learning because he was so distracted by the symbolic nature of his teacher's upright position, and the unconscious feelings that her position engendered in him. He constantly said that he just wanted to leave class, that he couldn't stand it there. His parents could not afford treatment, so a workable solution was found, i.e., he wore a protective cap while in class (to keep his head from being grabbed), and his desk and chair were put on a platform off to the side, so he was more highly elevated. In addition, he requested that the teacher spend more time sitting in a chair while she was teaching, and she agreed, giving him some symbolic power over the cesarean procedures that traumatized him (particularly the intrusive aspects). His learning improved and he had fewer problems for the remainder of the school year. Confrontive Recapitulation of Control. A case of confrontive recapitulation occurred at a Catholic school, known for its fundamental approach to religion and strictness about rules. A sophomore was referred for treatment because of his rebellion, subordination, and influence on other students (the school reported he was attempting to lead insubordinant efforts among the student body). We took a birth history and determined that he had been delivered by cesarean section under general anesthesia (highly unusual, but necessary because of a medical emergency). His mother was close to dying during the delivery. The client was accidentally cut by a surgical knife during his delivery and was also delivered by forceps. He was taken away from his mother and separated from her for weeks after his birth until she recovered. The father was not in the picture at all. In terms of presenting symptoms, he was known to own a switch-blade knife, and had been thrown out of school on several occasions for carrying it to school. He had also been known to threaten others with his knife (to "cut anyone who tries to tell me what to do"). This behavior represents i-type avoidance recapitulation, where he assumed the role of the surgeon. In spite of his threats and surly appearance, he was actually a "nice kid," well liked by his school mates, and had never done anything violent. As he himself (and as others) said, he is just "talking his

walk" (a slang expression meaning he was taking stances, but not being violent about it). He admitted to a fascination with knives of all sorts and had a collection at home. (Five to ten percent of cesarean born people have fascinations or abhorrences with cutting instruments, and/or consistently have cutting instruments in their major and repetitive dreams). He was also known to give weekly monologues at the "rap podium," which were well attended. Following are some segments from various monologues, to give a flavor of his confrontive recapitulations. These monologue segments are much more understandable when viewed as a metaphor for the process of cesarean surgery. In general, his messages were that the high school administration and some teachers were trying to tell them what to do and were trying to invade and control their lives with rules, religious beliefs, and dogmas. He said: ". . . they are cutting into our lives (the cesarean surgical cuts), they (the anesthesias and the forceps) take control of our bodies, our minds, leave nothing left but dispirited flesh and blood . . . and then inspect us like rodents (postbirth medical tests), picking apart our humanity like flies on a cadaver . . . they want to snatch us from our very homes we live in (the separation after birth), take us away from the territory that is sacred to us, to factories (pediatric evaluation rooms) where they inspect us, expect us to perform, test us with their instruments of divination, until we squirm and plead for deliverance from what they call education and humanity . . . we have to rebel against these evil forces, these imperialists of our minds, who seek only their gain, who seek and understand only fucking control . . . they want to take us over, man, totally have us at their will, turn us around like papier mache and inspect us with their microscopes, their instruments of torture (postbirth pediatric tests)." Surprisingly, he agreed to regressive treatment and was astounded to learn that most of his attitudes stemmed from his birth. He engaged his birth feelings deeply and passionately and, as he did so, lost what he called his "aggressive-edge." He was more able to see that school officials meant well and were just doing their jobs; and was able to work with parents and school officials to negotiate for changes that he and the student body wished to see occur. In short, he became a leader rather than a rebel. Each of the cases and examples involving traumatic impact on the birthing process and the resulting syndromes illustrate the original premise that medical interventions appear to have long-term detrimental (physical and psychological) effects and, because of this, even the most commonly used obstetrical interventions must be questioned. Footnote * An elaboration of these processes and other interventions and their results are described by Emerson (1996b). References REFERENCES Ainsworth, M. In Konner, Melvin. Childhood. Boston, Little, Brown, &Co. 1991, p. 90-91. Bloch, G. Body &Self: Elements of Human Biology, Behavior, and Health. Los Altos, Ca., William Kaufmann, 1985. Castellino, R. Cesarean Section Trauma, Impact and Treatment. Santa Barbara, Ca. (1105 N. Ontare, 93105), 1996. Chamberlain, D. B. "The Significance of Birth Memories." Pre and Perinatal Psychology Journal, 2, 136-154. Chamberlain, D. B. Babies Remember Birth: And Other Extraordinary Scientific Discoveries About the Mind and Personality of Your Newborn. Jeremy P. Tarcher. 1988. Chamberlain, D. B. "Toward a Developmental Nosology Based on Attachment Theory". Pre- and Perinatal Psychology Journal 3(1): 5-24. 1988. Chamberlain, D. B. The Adventure of Self-Discovery. State University of New York Press. 1988. Chamberlain, D. B. "The Outer Limits of Memory." Noetic Sciences Review, 1990. Cheek, D. B. "Sequential Head and Shoulder Movements Appearing with Age Regression in Hypnosis to Birth". American Journal of Clinical Hypnosis 16(4): 261-66.1974. Davis-Floyd, R. Birth as an American Right of Passage. Berkeley, Univ. of California Press, 1992. Emerson, W. and Schorr-Kon, S. Somatotrophic Therapy. In Innovative Therapy. London, Open University Press, 1993. Emerson, W. What is Birth Trauma? An Introductory Video Script. Petaluma, Emerson Training Seminars (4940 Bodega Ave., Petaluma, Ca. 94952), 1995. Emerson, W. Somatic Birth Simulation. Petaluma, Emerson Training Seminars, 1996a. Emerson, W. The Physical and Psychological Impacts of Obstetrical Interventions. Petaluma, Emerson Training Seminars, 1996b. Emerson, W. Regression Therapy with Adults. Petaluma, Emerson Training Seminars, 1996c. Farrant, G. "Cellular Consciousness." Aesthema (Journal of the International Primal Association) 7:28-39. 1986. Feher, L. The Psychology of Birth: Foundation of Human Personality. Souvenir Press. 1980. Fodor, N. The Search for the Beloved: A Clinical Investigation of the Trauma of Birth and Prenatal

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AuthorAffiliation William R. Emerson, Ph.D AuthorAffiliation William Emerson, Ph.D., an APPPAH Board member, is an internationally recognized authority on pre-and perinatal trauma. He conducts highly lauded seminars on his techniques. His videos on Treating Birth Trauma During Infancy are available from Emerson Training Seminars, 4940 Bodega Hwy., Petaluma, CA 94952. Note: A 114 page edition of this article is available with case examples and further elaborations.

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