

## Healing Through Prenatal and Perinatal Memory Recall: A Phenomenological Investigation

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**Publication info:** Journal of Prenatal & Perinatal Psychology & Health 15. 2 (Winter 2000): 146-172.

[ProQuest document link](#)

**Abstract:** None available.

**Full Text:** Headnote ABSTRACT: This qualitative study focuses on the experience of healing through prenatal and perinatal recall. Interviews were conducted with seven adults who variously attested to having healed conditions of: syncope, phobias, arthritis, asthma, migraines, depression, suicidality, obsessive-compulsion, side pain, and dysfunctional interpersonal patterns. Intentions were to: (a) illuminate the experience, (b) examine the benefits and drawbacks, and (c) underscore the impact of obstetric intervention. Literature Review: Reviewed literature includes research on transcendent, fetal, cellular, and somatic memory/consciousness (within a holonomic paradigm), current repression and false memory debates, hypnosis, breathwork, psychedelic, and primal psychotherapies, somatotropic therapy with infants and children, and obstetric intervention. Method: Existential-phenomenological research methods were used with Hycner's (1982) 15-step analysis for interview data. Two in-depth interviews, a demographics form, and a follow-up question were the instruments used to access data. Results: Data analysis revealed seven individual, two unique, and two general themes. The general themes included: "A Range of Intensely Felt, Mostly Negative, Emotional, Physical, or Feeling States, and Transpersonal Experiences," which captured the structural underpinnings of the phenomenon, and were expressed by all seven participants. All seven remembered pre- or perinatal trauma, and subsequent child abuse. Three remembered deleterious effects from obstetric intervention including long-term depression, slowed labor from anesthesia, pain from forceps, and vertigo from inversion at birth. After treatment all co-researchers felt the mitigation of psychological and/or physical conditions they had suffered. Conclusions: Results imply fetal/neonatal memory/consciousness and the need for research into the long and short term effects of obstetric procedures. Trauma occurring during and before parturition may cause life-long physical and/or psychological illness. The resolution of such illness may necessitate intervention at pre- or perinatal levels of memory/consciousness and that the parental relationship and maternal readiness for labor and delivery may be indicators of subsequent traumatic labor and delivery, and/ or child abuse.

**INTRODUCTION AND SIGNIFICANCE** This article examines the birth, gestation, and conception memories of seven adults (participants) who, by virtue of those memory experiences, claimed to have alleviated or cured conditions of: syncope, phobias, arthritis, asthma, migraines, depression, suicidality, obsessivecompulsion, side pain, and dysfunctional interpersonal patterns. The entire study consists of five chapters: 1) Introduction and Significance; 2) Literature Review; 3) Methodology; 4) Results and Discussion; and 5) the Appendix. Since space does not permit me to include the entire work, the following is intended as a synopsis with examples of its salient contents. One of my underlying motivations for conducting a study focused on prenatal and perinatal recall was more than merely suggesting that remembering birth and before is a possibility. After all, thousands have remembered being born. I wanted, rather, to go a step farther, to show that very practical reasons exist for pursuing those memories. secondarily, the study was designed to demonstrate possible long and short term effects of common obstetric intervention. By gathering a group of seven people who claimed to have mitigated serious physical and psychological conditions through prenatal and perinatal recall, and by examining and reporting their experience I believe I have accomplished my goal. **LITERATURE REVIEW** This review is a survey of the prenatal and perinatal psychological literature, supporting studies, and studies and opinion in contrast. Unfortunately, mainstream psychology sources are virtually devoid of material on this subject. Instead I have included various opinions on the concept of repression, since without it prenatal and perinatal memory recovery would not exist. Representative portions of some of the original topics are presented here with

samples of supportive documentation. In the interest of brevity, I have shrunk a 67 page review into 13 pages. Much of the documentation has been cut, as well as the sections reviewing myelination, psychoanalytic history, the psychotherapies, and obstetric intervention. What remains, essentially, is the argument for the viability of prenatal and perinatal memory, a new scientific paradigm, and the defense mechanism of repression.

Mainstream Versus Alternative Scientific Opinion Perhaps because babies cannot talk, prenatal and perinatal recall remembrance is difficult to prove. Anecdotal evidence of the phenomenon is easy to come by, but controlled studies are not. Therefore, testimony to its veracity is dismissed by the scientific and psychological communities in favor of the also unproved but long-trusted theory of "infantile amnesia." The concept that a state of complete amnesia is normal in all persons before the age of three or four is based on the idea that most adults and older children do not usually have memories for events occurring before that age (Eisenberg, 1985; Howe & Courage, 1993; Loftus, 1993; Pillemer & White, 1989; Wakefield and Underwager (1994), and on the speculation that the delayed maturation of the hippocampus of the brain somehow precludes memory and/or consciousness (Jacobs & Nadel, 1985). According to Wakefield and Underwager (1994), "Even if we accept that some memories may be retrieved from age two, no study supports the ability to recover memories at or near birth" (p. 176). Ewin (1994) states that while controlled studies of birth memory may be scarce, it only takes one case to "Void a statement that something never happens" (p. 175). He refers to two classic studies, one on imprinting with newly hatched birds by Nobel Prize-winning Konrad Lorenz (1935) and the other on human imprinting (Cheek, 1986; Rossi & Cheek, 1988). I believe the point that Ewin (1994) makes is that mainstream psychology's neglect of the phenomenon of prenatal and perinatal memory is akin to throwing the baby out with the bathwater. That is, veridical studies like those of Cheek (1986) and Lorenz (1935) that stand the test of time and meet natural scientific standards are dismissed along with the empirical and anecdotal material of the field. The subject is written about and researched by alternative psychologists and virtually ignored or used to exemplify the improbable or the absurd by the mainstream. In an article denouncing "memory work" in psychotherapy for childhood sexual abuse (CSA), Lindsay (1997) describes what he seems to believe is a consensus: For one thing, there are documented real-world cases in which people recovered memories that are demonstrably false or extremely implausible. Examples include reported memories of bizarre and murderous satanic rituals; memories of abusive events during the first days of life, or even in the womb . . . The point of citing such examples is not to imply that all experiences of memory recovery should be attributed to the same mechanisms that give rise to illusory memories and false beliefs such as these; rather, the point is merely that such cases demonstrate that people can experience illusory memories of traumatic childhood events. (Lindsay, 1997, p. 7)

Memory, Consciousness, and a New Paradigm The Newtonian-Cartesian paradigm has dominated Western thought in its many manifestations for about the last 300 years. The prevailing belief has been that reality is fundamentally material, and that the universe is governed by a system of firm, unchanging, and absolute principles (Grof, 1985). This dominance can be seen in the "scientific method," a process by which the mainstream scientific community establishes validity. The method calls for the controlled, reproducible, and witnessed execution of a given phenomenon. Generally, anything failing to fit into and meet this standard of reality testing has been denounced or held suspect. Reductionist conceptions of reality have also held sway over the "softer" person-oriented sciences, like psychology, psychiatry, and sociology. With a rigid scientific standard being applied to research in these areas, progress has been severely held back. Personality and consciousness have been seen as the outcomes of drives or instincts, in Freudian terms, or as a result of the developing central nervous system (CNS). That personality could be a product of mind, continuing its development through lifetimes of experience would not be a viable concept. Further, there has been little support for consciousness research, for under Newtonian terms, consciousness must be shown to be a product of the brain or the CNS to be legitimate. Creativity has had nothing to do with a person's connection with the whole of universal consciousness; rather, it is a consequence of genetics. Examples of phenomena thought to be hallucination, figments of the imagination, and products of the CNS, in the Newtonian-Cartesian paradigm of

reality, are: inspiration, the power of prayer, the power of faith, meditation, spirituality, God, love, phenomenology, and prenatal and perinatal memory or consciousness. According to Grof (1985): Mechanistic science tries to explain even such phenomena as human intelligence, art, religion, ethics, and science itself as products of material processes in the brain. The probability that human intelligence developed all the way from the chemical ooze of the primeval ocean solely through sequences of random mechanical processes has been recently aptly compared to the probability of a tornado blowing through a gigantic junkyard and assembling by accident a 747 jumbo jet. (Grof, 1985, p. 23) Late in the nineteenth and early in the twentieth centuries evidence surfaced of certain physical phenomena that could not be explained completely with mechanical rules of causation. These rules had the effect of law until that time, at least for the "hard" sciences, such as, biology, chemistry, and physics. Rising inconsistencies heralded the beginning of a new system of thought. However, according to Wade (1996), these concepts are not really so new. "Physicists have been postulating a deep unitive reality for over fifty years, and Western philosophers (e.g., Plato, Plotinus, Spinoza, Hegel) have been postulating such a reality for much longer" (pp. 8-9). Differing from Newtonianism on matters such as "time and space, matter and mind, and science and spirituality," the evolving paradigm has creative consciousness as its emphasis, rather than materialism (Wade, 1996, p. 2). A greater understanding of creative consciousness can be gained with the help of the theories of the late David Bohm (1980). A theoretical physicist, Bohm was a prime mover of the new conceptions of mind and the universe. He described the nature of reality in general, and the nature of consciousness in particular as, "an undivided whole in perpetual flux." As such, the "empty space" concept of material science, in which humankind and other matter ostensibly exists, does not exist. To Bohm, space is composed of energy in constant movement -"holomovement. " Humanity is a mere portion of this energy, an uninterrupted, integral piece of the whole. Bohm derived his holographic or holonomic theory from the concept of holography, a three-dimensional, lensless photography, in which the whole of the image can be seen in each of its parts. As integral parts of the holonomic or holographic universe, we can imagine that each of us contains information about the whole or any part of the universe. (Bohm, 1980; Grof, 1985; Pribram, 1982). Fetal consciousness, capable of nascent cognition, learning, and inchoate individuation is thought to be contingent on the CNS and possibly some physical structures such as RNA, or other biochemical messengers; transcendent consciousness is considered to be mature and unchanging (Wade, 1996, p. 32). The following exhibits research illuminating the nature of both types of consciousness. I could not find commentary or studies in contrast to this work in any refereed journal. Perhaps, as Chamberlain (1988) suggests, the focus of Western science on the immaturity of the infant brain has prevented the recognition of newborn and fetal competence. Extensive searches revealed studies on the intelligence and capacity of newborn kittens and monkeys but not of human neonates. Studies of fetal conditioning and sensation and studies of older human infant capabilities are available but do not apply to my study of prenatal and perinatal memory and consciousness. In a well known study demonstrating the consciousness and sociability of twin fetuses was conducted by Alessandra Piontelli (1992). Four sets of twins were observed by ultrasound, periodically over the course of the pregnancies. Follow-up observation was conducted through age four. One of the most striking features for Piontelli was seeing that behavior after birth was on a continuum with what had been happening before birth. Loving, fighting, and dependency behaviors between the twins were seen through the ultrasound lens as they kissed and hugged, or punched and kicked each other repeatedly. Each pair seemed to manifest a certain theme with their behavior: one set was loving, another contentious, and yet another was passive. The loving pair consisted of a boy who was active, attentive, and affectionate and a girl who would follow his lead. The male of the pair appeared to feel claustrophobic as he kicked and wrestled with the placenta, constantly pushing for space and looking disgruntled. He was, however, seen reaching out to his sister through the membrane that separated them, caressing her cheek or rubbing her feet with his. The female twin reciprocated in kind. Postnatal notes on this twin pair found them just as affectionate as they were prior to their birth. At one year of age, they could be seen playing with each other, a curtain between them as if a dividing membrane, touching, hugging, and kissing. The

little boy of the pair was as self-starting, independent, and intolerant of limitations as he was known to be before birth. The other twin pairs manifested the same types of behaviors postnatally, as they had prenatally, often acting as if they were still vying for space. One mother commented to Piontelli as her twins attempted to pass through the door at the same time, "They always have to collide to get in ... as if there was no space for two .. ." (Piontelli, 1992, p. 123). Concepts of the bodily retention of memory can be traced back at least 100 years to Pierre Janet (1889) who believed that intense emotional responses are dissociated from consciousness and stored viscerally as anxiety and panic, or as visual images of nightmares and flashbacks. In Freud's (1919/1954) studies of wartime neuroses he declared that his patients had been physically fixated to war trauma. In search of engrams, the ostensible locus of memory, Karl Lashley trained experimental animals, systematically damaging parts of their brains, for 30 years. His conclusion was that removing parts of the brain worsened the animals' performance but could not eradicate what they had learned (Lashley, 1929; 1960). Lashley's conclusion that memory cannot be localized in any one area of the brain has been criticized on the basis that his experiments were based upon that idea (Wolfgram & Goldstein, 1987). In contrast, Penfield (1959) in conducting brain surgery with epileptic patients, arrived at conclusions opposite from Lashley's localization results. By electrically stimulating the temporal lobes of the brain, the physician elicited early childhood memories in some of his patients. In spite of this, Penfield (1975) believed strongly that the human mind is not attributable to the CNS. About this and in response to a colleague he wrote: That is the correct scientific approach for a neurophysiologist: to try to prove that the brain explains the mind and that mind is no more than a function of the brain. But during this time of analysis, I found no suggestion of action by a brain-mechanism that accounts for mind-action (Chapter 17). That is in spite of the fact that there is a highest brain-mechanism and that it seems to awaken the mind, as though it gave it energy, and seems itself to be used in turn by the mind as "messenger." Since I cannot explain the mind on the basis of your "assumption," I conclude that one must consider a second hypothesis: that man's being is to be explained by two fundamental elements. (Penfield, 1975, p. 104) The following studies suggest a physical basis for memory that involves the cellular chemistry. They also may indicate a coding of peptides for memory (Wolfgram & Goldstein, 1987). McConnell (1962) trained flatworms to turn away from light. He then discovered that by feeding the trained worms to a group of untrained worms they would learn to avoid the light more quickly than the original group. He concluded that the latter group learned more quickly because chemicals associated with the conditioned response were made available to them. In a similar study, Ungar (1967) trained normally nocturnal rats to avoid the darkened part of a box by placing electrified screens in the area. He then made extracts from the rats' brains and discovered the presence of a new peptide. By artificially duplicating the peptide and injecting it into untrained nocturnal rats, he found the latter group of rats would automatically avoid the darkened part of the cage. Pribram (1971) advanced his holographic theory of memory storage in *Languages of the Brain*. He posited that memory is stored in every cell of the body as opposed to in the CNS alone. As such, each cell contains information about the whole. Further, he felt that the brain may function as a "spectral analyzer," recording images by holography and distributing information to all of its parts (Pribram, 1986). Studies of traumatized individuals confirm consistent physiological response to stimuli reminiscent of traumatic incidents, such as heart rate, skin conductance, and blood pressure (Kolb & Multipassi, 1982; van der Kolk & Ducey, 1989). These symptoms are also recorded by Grof (1985) and Janov (1983) when referring to individuals reexperiencing birth. About PTSD survivors van der Kolk (1996) writes, "The highly elevated physiological responses that accompany the recall of traumatic experiences that happened years, and sometimes decades before, illustrate the intensity and timelessness with which traumatic memories continue to affect current experience" (p. 5). According to van der Kolk (1996) people with PTSD chronically suffer from the persistent activation of the biological stress response. Increased levels of epinephrine and norepinephrine, abnormally low urinary cortisol excretion, and increased amounts of lymphocyte glucocorticoid receptors are common in PTSD sufferers. He points to the development of decreased CNS serotonin levels in inescapably shocked animals, and the fact that

serotonin re-uptake blockers are effective pharmacological agents in the treatment of PTSD as evidence of the physical memory of trauma. Further, van der Kolk (1996) maintains that the limbic system, that part of the CNS which records the emotions and behaviors necessary for survival, is critically involved with the storage and retrieval of memory. This information coupled with Pert's (1987b) and Pert, Ruff, Weber, and Herkenham's (1985) contention that the limbic system is partially mature at 4 weeks of gestation and fully formed by the third trimester of prenatal life lends additional support for the feasibility of pre-and perinatal somatic memory.

Repression or Dissociative Amnesia While literature of the prenatal and perinatal genre does not hold sway with mainstream psychology, parts of a current decade-old, rather heated debate over the nature and veracity of recovered traumatic memory can apply. The controversy began in or about 1990 in response to sharp increases of reports of childhood sexual abuse recalled by adults (Wakefield & Underwager, 1994, p. 6). As a result, many states changed statutes of limitation concerning sexual molestation to begin when the victim remembered the abuse even if that was many years after the purported occurrence. This has opened the courts to suits against accused perpetrators for events alleged to have occurred as far back as 40 years. Malpractice among psychotherapists is at issue, as well as the reputation of the field of psychotherapy, as accusations of the implanting of false memories are made (Alpert, 1995). In the main, the argument rests upon whether the widely accepted Freudian concept of repression actually exists. Opponents are generally experimental or cognitively oriented psychologists, usually not psychotherapists, and often bear expert witness in the defense of accused perpetrators. Proponents, on the other hand, are usually psychoanalytic or psychodynamically oriented psychotherapists whose basic therapeutic tenets depend on the function of repression (Karon & Widener, 1998). Since theories of prenatal and perinatal memory recovery rest upon the concept of repression (Nichols, 1996; Ruch, 1986; Wade, 1996), the issue then becomes germane to this discussion. Current use of the concept of repression includes the unconscious forgetting of trauma related and not to the libidinal (sexual) drive but threatening to the integrity of the self. Another definition with a less traumatic connotation is, "Repression simply means removing something from conscious awareness or keeping something out of conscious awareness because of the unpleasant affect connected with it" (Karon & Widener, 1998, p. 483). Freud (1896/1974) used the term repression to represent a universal psychological defense mechanism which prevents the awareness of painful or unacceptable wishes, thoughts, fantasies, and memories. Most childhood sexual abuse and most, if not all experiences of birth can be considered traumatic. As such, and because the defense mechanism of repression is said to protect the integrity of the self from traumatic overload, and because everyone theoretically represses or maintains no memory of birth, I feel that this literature, with certain qualifications, can provide material worthy of consideration. One obvious drawback to the comparison of prenatal and perinatal memory with that of early memories of CSA is that the brain development of young children is far advanced over that of prenatals and perinatals. Studies measuring the memory capacity of young children have shown that it increases dramatically with maturity (Campbell & Spear, 1972; Campbell, Misanin, White, & Lytle, 1974; Terr, 1994). Therefore, attempting to explain prenatal and perinatal memory, especially with the vividness and clarity that sometimes manifests, with the CNS theories used to explain infantile amnesia and repression is fruitless. Still, veridical studies documenting prenatal and perinatal recall have exhibited a viable mechanism, albeit to date unidentified, which permits detailed recall after many years of amnesia (Chamberlain, 1986; Grof, 1985, Wade, 1996). Further, credence should be given to the verity of cases of traumatic perinatal recall that result in total body involvement, with phenomena such as: forceps marks showing on the head, great difficulty in breathing to the point of cyanosis, and verified reports of the amelioration of physical or psychological impairment (Grof, 1985; Janov, 1983; Ruch, 1986). These data present ample evidence of repression, and solve the conundrum of whether or not it exists. That this is denied categorically, by most psychologists, however, ostensibly because belief in infantile amnesia does not permit concurrent belief in prenatal and perinatal recall without the discomfort of cognitive dissonance, is where the Newtonian paradigm breaks down and a holographic point of view must naturally succeed. A holographic viewpoint sustains concepts such as that the mind is not the brain

(Pert, 1987b) and that the brain and the mind sometimes function together, and sometimes not. Among psychologists, there is a range of opinion about repression from complete rejection to fanatical pursuit. Holmes (1974,1990); Loftus and Ketcham (1991, 1994); Ofshe and Waiters (1993); and Pope and Hudson (1995) do not believe that the mechanism exists. In the recovered memory dispute this group is known as "false memory advocates." Brandon, Boakes, Glaser and Green (1998) expressed this point of view, "There is no empirical evidence to support either repression or dissociation, though there is much clinical support for these concepts" (p. 304). Bowers and Farvolden (1996) believe that repression does exist but that it is rare (p. 359). In their examination of the evidence in favor of and against repression they suggest that not everything need be proven in a laboratory. Alpert, Brown, Ceci, Courtois, Loftus, and Ornstein (1996), the APA working group on the investigation of memories of childhood abuse, concluded that it is possible to recover long forgotten memories of childhood abuse, and conversely, to have false memories created through suggestion. Among prenatal and perinatal theorists, therapists, teachers, and researchers there is virtually no disagreement that effective treatment for prenatal and perinatal trauma involves the bringing to consciousness of the repressed material surrounding it. Helping participants to integrate catharted feelings, emotions, and memories is also important, but fundamentally, the release of repressed energies is central to resolution. Kihlstrom (1997) has determined that age regression is, "... an imaginative reconstruction of childhood, not a reversion to the genuine article" (Kihlstrom, 1997, p. 1730). He adds, "There may be some memory enhancement produced by hypnotic age regression, but age regression is first and foremost a product of the imagination, and any accurate memory produced is likely to be blended with a great deal of false recall." Brandon et al. (1998) concur with Kihlstrom, "Accounts are at times so fantastic that they are beyond belief and there is no evidence of the efficacy of this technique" (Kihlstrom, 1997, p. 301). The following study provides some of the missing evidence. Raikov (1980) described the Babinski reflex as an outward, toe-fanning reaction seen only in newborn infants when the bottom of their foot is stroked. With greater brain maturity, the Babinski reflex is replaced by a curling under of the toes. Since the Babinski reflex is never seen in healthy adults, it is commonly used to diagnose neural impairment such as stroke. He hypnotized 10 highly hypnotizable men and women, ages 19 to 29 years, to the state of early infancy. The depth of their hypnotizability was determined by the following criteria: complete amnesia for the hypnotic experience and an adequate form of behavior corresponding to the suggested age of regression. When regressed to a verbal developmental level, each subject could converse with someone present in the regressed scene without paying attention to suggestions from the hypnotist. The developmental stage of early infancy was chosen because it was felt that newborn movements would be most instinctual and automatic and therefore the most difficult to deliberately reproduce. The seven criteria of the newborn level were not determined until after the regression because, "... the hypnotist and the neuropathologists did not know at all precisely what neurological reactions should take place in the newborn" (Raikov, 1980, p. 159). The regression was observed, photographed, and video recorded. Attempts were unsuccessfully made to get the subjects to answer commands such as to open their eyes and to tell their ages. Also an attempt to physically force their eyes to open was unsuccessful. Sucking and grasping reflexes were observed both spontaneously and responding to touch. Newborn "cries" without tears and Babinski reflexes were observed. The uncoordinated movements of the eyeballs endured throughout the entire course of the suggested infancy. Material obtained by one of the neurologists and compared to the photographs and videos of the age regressed adults confirmed accurate newborn reflexive behavior. From this information, the following seven criteria were distinguished: \* Babinski reflex \* Uncoordinated eye movements \* A sucking reflex \* A grasping reflex \* "Infant's" cry without tears \* The "infant's" movements of the extremities \* The infant's bending reflex of the foot The Babinski-like reflex occurred for 5 of the 10 subjects. Uncoordinated eye movements occurred in all subjects as did the spontaneous sucking reflex. The grasping reflex occurred in 4 of the 10, movements of the extremities in 4, and the infant cry with no tears in 5. The footbending reflex occurred in 6 of the 10 subjects. No subjects showed fewer than 2 of the 10 criteria, and 1 subject showed all of them. Despite the demonstration of phenomena such

as the Babinski reflex and uncoordinated eye movements in RaikoVs (1980) study, Kihlstrom (1997) insists: {S}tudies employing a wide variety of experimental paradigms, including the Babinski reflex, various illusions which show developmental trends, and a host of tasks derived from the developmental theories of Heinz Werner and Jean Piaget (not to mention psychoanalysis), have yielded nothing by way of replicable evidence of ablation or reinstatement, (p. 1730) Conclusion Reviewing some of the existing literature demonstrates some of the difficulties awaiting a psychologist who might attempt to prove the existence of the defense mechanism of repression. This excerpt also included arguments for and against concepts of prenatal and perinatal memory, the defense mechanism of repression, and the emergence of a new scientific paradigm. METHODOLOGY The phenomenological method is a careful analysis of reflective interview data which reveals the common and unique underpinnings of the chosen experience. By applying visual, aural, and intuitive faculties, individually, to the language, inflections, movement, and intentions of a small number of participants the researcher can identify and group both similar and unique areas of feelings, emotions, and perceptions. This process creates a subjective "snap shot" of the experience in question. The word "existential" from the term, "existential phenomenological psychology," refers to the philosophy of existence or the study of being. The word, "phenomenological" describes a methodology used to study a person's experience. This type of research focuses upon the quality of a given experience rather than it's quantification. It requires that a phenomenon (or type of experience) be selected for study. Selection could be as basic as the experience of gardening, or as unusual as birth remembrance. Because perinatal recall phenomena cannot be replicated, quantified, or controlled, I chose an existential phenomenological research approach for this investigation of prenatal and perinatal memory. Data consisted of an audio recorded oral interview. Each participant was asked to address the question: "What is the experience of healing through the remembrance of the prenatal and perinatal period"? A second recorded interview was then conducted by reading the transcribed first interview aloud to the participant. This process encouraged the participant to add, take away from, or modify the first interview. Later, a follow-up question was asked: "What was healing about this experience for you?" Answers to this question highlighted the healing aspects or what was gained from the experience. Finally, a demographics form focused on aspects of abusive domestic situations was completed in order to examine the unexpected, unanimous claims of child abuse made by the participants. Following are the main steps in the phenomenological data analysis. Transcription The interviews were transcribed verbatim. The following is an excerpt of one participant's response to being asked about her experience of healing through recalling prenatal and perinatal memories (For reasons of confidentiality all the participant's names have been changed). I basically didn't believe ... I mean it just sounded too bizarre to me that there could be some sort of "rebirthing." The whole thing just sounded very bizarre to me, but ... I thought, "What the heck. Nothing ventured, nothing gained." (The participant describes working with a therapist around the issues of her birth.) I started doing the guided visualization, the guided imagery and ... I felt very disconnected from, until the point ... I felt very disconnected from everything until the point where (I was asked) to remember or asked what it felt like at the moment of my conception. And I immediately felt rage. I guess my face got all red. And, I felt that I had been conceived in a rape. Good ol' marital rape. Happens a lot more than people want to talk about. It was a marriage of convenience for my mom. Unfortunately my poor father was totally head over heels in love with the woman. Nothin' sadder than that. And I thought that both my parents were very angry. And I was very angry. And I didn't want to be there. I didn't want to be there. At the same time, I felt like I was swimming around. I didn't feel like there was anything I could attach to. I didn't feel like there was anything, you know, warm or nurturing about the experience at all. And I felt like I was swimming around in a sewer. There was also at the same time, I had gotten extremely ill with asthma, which I had had my entire life. I was really sick enough that I probably should have been hospitalized. But I couldn't do the whole med thing anymore. At that point I think I was on 14 different meds. I was on a full battery of everything. From antibiotics to bronchodilators to steroids to three different kinds of inhalers. And I was just a mess. And during this whole thing I was wheezing and coughing and getting worse

as this thing [the session] went on. And I was really afraid that I was going to get into a really serious you know kind of grand mal asthma attack. But I also didn't feel like ... I felt trapped. I didn't feel like I had an option. I mean I felt like I was trapped in this experience. And that's just the way it was, actually. I didn't really think about it in any objective sense that I could stop the experience or you know, quit in any fashion. So the regression continued. And I can't remember exactly how it progressed but I remember that it was harder and harder to breathe and I was feeling more and more trapped. And I was feeling crushed. And that. . . that. . . like I was going to die. I really felt like I was going to die. And I remember starting to yell out or scream out, "No!" And at some point . . . And I was coughing and couldn't breathe. It seemed to be getting worse. And at some point I started screaming. I just started howling. And it was like I took the first deep breath of my life. And it was, it was ... my asthma broke and I took this deep breath that seemed to extend down to my toes. And I felt like I was breathing, that I had taken the first breath, the first deep clean breath that I had taken in my entire life. And when my asthma broke I knew at that moment, and I don't know why I knew it or how I knew it but I knew at that moment that I was never going to have asthma again the way I'd had it. That it was gone. And all the wheezing stopped and all the coughing stopped and my lungs were clear. And I could breathe again.

**Forming Units of Relevant Meaning** The transcripts were then broken down into units that expressed unique, coherent meaning. Each of these phrases or sentences was delineated and recorded as a unit of general meaning. Of the units of general meaning those that directly pertained to the investigated phenomenon were underlined, extracted from each protocol, and logged as units of relevant meaning. Redundancies were eliminated. There were 87 units of relevant meaning explicated from Rachel's entire interview. The following are the first eight: Eight of Rachel's Units of Relevant Meaning \* She did not believe in birth regression \* The whole thing sounded bizarre to her \* She thought, "Nothing ventured, nothing gained" \* She felt disconnected from everything \* Then (the therapist) asked her what it felt like at the moment of her conception \* She immediately felt rage \* Her face got all red \* She felt she had been conceived in a rape

**Forming the Cluster Headings** Cluster headings for relevant meaning units were then formed for each of the seven participants by sorting like units of relevant meaning into clusters under descriptive headings. Rachel's cluster headings included: \* Rage at Being Conceived in a Rape \* Feeling Her Parents Anger \* Struggling to Implant in a Toxic Womb \* On the Verge of a Grand Mal Asthma Attack [sic] \* Feeling Trapped in the Experience \* Worsening Feelings of Being Trapped, Crushed, and of Suffocating and Dying \* Feeling the Asthma Break \* The First Deep, Clean Breath in Her Life \* Still Feeling Trapped and Stuck but Being Able to Breathe \* Feeling as Though She Must Stay Huge to Avoid Being Crushed \* Feeling Beat Up, Crushed, Pummeled, and Hurt All Over \* Exhausted and Alone \* Depressed, Sad, and Angry \* Suffocation

**Determining Individual Themes From Cluster Headings** Another grouping of the data occurs which renders the individual themes. They are developed from the cluster headings of each protocol by combining those headings which are very similar in meaning under descriptive headings or themes. After careful explication of each of the protocols through verbatim transcription, and groupings of general units of meaning, relevant units of meaning, and cluster headings, the all-important, underlying themes of the experience emerge. A list of the themes representing their subjective experience was developed for each participant (Table 1).



**Table 1**

<i>Individual Themes for All Participants</i>	<i>Number of Participants with Theme</i>
<b>Anguished Emotional, Physical, and Feeling States</b>	(7) 100%
<b>Relief or Healing</b>	(7) 100%
<b>Perception of Mother's or Others' Reality</b>	(6) 86%
<b>Consciousness as Separate From Body</b>	(4) 57%
<b>Feeling Overtaken or Trapped by Experience Itself</b>	(3) 43%
<b>Light of Healing, Compassion, and Love</b>	(1)14%
<b>Loving and Losing a Twin</b>	(1)14%

General and Unique Themes Two general themes emerged from the reduction of the individual themes. All seven participants expressed experience consistent with both general themes. The first general theme: A Range of Intensely Felt, Mostly Negative, Emotional, Physical, and Feeling States, is essentially self-explanatory. Many types of negative and a few positive experiences were reported, constituting this general theme. Just as each of the participants was motivated to explore the prenatal and perinatal realm by a painful condition(s), the alleviation of these conditions involved a painful reexperience. Transpersonal Experience, the second general theme, was also reported by all the participants. The remembrance of the prenatal and perinatal realm in any form can be called transpersonal by virtue of its being an "expansion or extension of individual consciousness beyond the usual ego boundaries and limitations of time and space," (Grof, 1973, p. 35), and an extraordinary human experience (Sutich, 1969). The themes of The Light of Healing, Compassion, and Love, and Loving and Losing a Twin have been categorized as unique themes as they were reported by one participant only. This section has shown the major steps in data analysis and the rendered themes from this phenomenological study. The next section contains more results and a discussion.

**RESULTS AND DISCUSSION** Results from a phenomenological investigation can be expressed in forms besides the individual, general, and unique themes. They are also presented in summaries written by the researcher, and modified, if necessary, by the participant. Other ways of showing results include: themes exemplified by quotations from the original interviews; themes and textual quotations used to underscore the work of psychologists and scholars in the field; and composite summaries. The original study contains all of these presentations and more.

Previously, I expressed my hope of illuminating the experience of healing through the remembrance of the prenatal and perinatal period. secondary objectives included examining the healing benefits of the experience, and raising awareness of the long- and short-term side effects of routine obstetric intervention. I believe the study was successful in its first two aims, at least. Illumination of the experience of healing through the prenatal and perinatal recall can be seen throughout the following section.

**A Painful and Scary Transpersonal Experience** Two descriptive categories represent the structure of the experience under investigation, in general. The themes, Intensely Felt, Mostly Negative, Emotional, Physical, and Feeling States, and Transpersonal Experience capture the essence or underpinnings of the phenomenon. All of the participants in this study expressed their experience of healing through the remembrance of the prenatal and perinatal period in painful terms. In fact, the word "pain" or "painful" was used 62 times in all of the life-texts combined. "Excruciating" was mentioned 11 times, "crushed" or "crushing" 19 times, "pressure" 32 times, "terror" 12 times, and "panic" 14 times. Remembering the prenatal and perinatal period, then, at least for those who have been traumatized by it, could be called, "A Painful and Scary Transpersonal Experience." Perhaps naively, I did not expect the data analysis to reveal such pain. Apparently, the experience of healing trauma severe enough to produce psychological and physical disorders, through prenatal and perinatal remembrance, is often a virtually joyless

proposition. Results of the Follow-up Question In spite of the preponderance of negative expression in this study the participants qualified for the study on the basis of their healing results. Because the first and second interviews elicited mainly the recollection of intense pain and discomfort, and not the positive returns, the need for the following question became apparent: What about your prenatal and perinatal experience was healing for you? Asking the follow-up question gave the participants an opportunity for a reflective expression of the benefits of their experience. What follows is a summary of their answers of each of the seven participants.

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

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

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

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

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

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

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

The participants demonstrated an impressive array of results reporting feeling healed on spiritual, emotional and physical levels. Their gains were noted from the outset of the study. Among other results, Karlton's vision improved, Jesse's back and side pain condition was cured, Caroline's various phobias were alleviated, Douglas's migraine headaches and syncope were cured, Rachel's asthma was healed, and Caroline's arthritis symptoms were improved. Since qualifying for the study required the pivotal healing of a physical or psychospiritual condition brought about through pre- or perinatal recall, it is not surprising that the experience affected the participants in profoundly positive ways. Emotional healing, however, was considered by most of the interviewees to be more important than mitigation of their physical conditions. My interpretation of these expressions of healing include, self-empowerment, a feeling of more control over life, and freedom from anger and hatred. Further, all participants expressed their healing in terms that indicate an overall enhancement of the quality of their lives.

Results of the Demographics Form An unexpected outcome of the research was that all of the participants felt abused by their parents as children, most in multiple ways. Alcoholism, neglect, and domestic violence, as well as sexual, physical, and emotional abuse became apparent through the protocols and demographics form. Further, six of the participants remembered varying types of abuse or neglect in utero. Marisa, Caroline, and Douglas felt unloved and unwanted. They also complained, by virtue of having received anesthetic, of having to do the labor of birth on their own. Rachel remembered conception during "marital rape," Amy suffered the profound rejection of abortion attempts and adoption, and Jesse was actually punched in the third trimester. In relation to the reviewed literature, and as far as I have known or heard, this finding is unprecedented. Many of the prenatal and perinatal

traumatic memories and subsequent child abuse recall of the participants may represent the consequences of a combination of unprepared, dysfunctional people creating unwanted children, and obstetric intervention without full knowledge of its consequences. Negative domestic conditions such as substance and sexual abuse, domestic violence, and unplanned pregnancy were in place at the time of conception through birth. The resulting lack of involvement and enthusiasm on the mothers' part in the birth process, and the apparent ignorance of the medical establishment regarding the impact of obstetric intervention may have led to excessive anesthetic usage, forceps deliveries, reduced maternal participation, prolonged labor, and the improbability of bonding. Routine Obstetric Intervention An illumination of the long and short-term effects of routine obstetric intervention was possible through the original interviews. The alleviation of depression on Douglas's part after reexperiences of anesthesia during labor provides some insight as to a possible long-term consequence. Marisa and Caroline related feeling that their mothers stopped helping with the labor after being anesthetized, that the labor was slower, and that they felt they had to do all the work. About this, Ruch (1986) writes, "... many reported difficulty breathing, felt immobilized or held back, and shared a sense of having to do all the work of delivery by themselves" (Ruch, 1986, p. 190). Douglas and Marisa complained of the pain that forceps gave them. Further, Marisa experienced the doctor's use of forceps as a "rip off since she had struggled valiantly to be born and felt her journey was intercepted and the "triumph" of her birth preempted. Caroline recalled surgery without benefit of anesthetic immediately after birth. Born with Rh negative blood, she required a transfusion and was cut several times without being anesthetized. While the transfusion could not be classified as a routine obstetric intervention, it does exemplify the decades during which medical science espoused the belief that babies could not feel pain (Chamberlain, 1991). Fetal and Transcendent Consciousness At least two types of consciousness became apparent throughout the study, that of fetal and transcendent. This can be seen in the testimony of the participants while describing their plight. Fetal consciousness is tied to the fetal body, whereas, transcendent is a mature consciousness thought to be located outside of the baby and the mother. It is thought to attach to the fetus sometime during the third trimester, or within two days of birth (Wade, 1996). Awareness of parental experience on the part of the participants is an example of transcendent consciousness. Six of the seven participants expressed having this ability. A Comparison of the Findings With the Literature Review This comparison revealed a confirmation of the reviewed literature in support of fetal and neonatal consciousness and memory. If these data are to be believed, the concept of repression is strongly supported. It is at odds with those who profess it to be impossible (Kihlstrom, 1997; Loftus & Ketcham, 1994; Pope & Hudson, 1995). Because of established requisites phenomena such as healing through prenatal and perinatal recall cannot fit within the traditional scientific paradigm. These principles, including the "scientific method," require that phenomena (a) be replicable under controlled circumstances, (b) be quantifiable, and (c) be experienced by one of the five basic human senses. It is patently accepted that memory and consciousness are an outcome of the maturation of the CNS. All of this is in contradiction to the current study. The interviewees related their prenatal and perinatal recollection and the ostensible symptom alleviation for purposes of this study but controlled replication is not as yet possible. Rather, I submit that this study offers significant support in favor of a holonomic paradigm (Bohm, 1980). If one accepts the results of the current study as veracious, then concepts such as incomplete myelination, infantile amnesia, and an immature CNS which prevent prenatal and perinatal memory are seriously challenged. Literature suggesting that myelination is an unnecessary component to prenatal and perinatal memory may be validated instead (Chamberlain, 1988; Grof, 1985; Pearce, 1992; Verny & Kelly, 1981; and Wade, 1996). Further, if it is true that what the interviewees claimed to have experienced was the memory of their prenatal and perinatal life, memory theory other than that attributed to the CNS, that is, Bohm's (1980) theory of holonomic memory, Sheldrake's (1995) morphic resonance, and conceptions of cellular and somatic memory (Buchheimer, 1987; Farrant, 1987; Pert, 1987b; Pribram, 1970; van der Kolk, 1996; van der Kolk & van der Hart, 1991) are also supported by the evidence presented herein. The neuropeptide research of Pert, Ruff, Weber, and Herkenham (1985), van der Kolk's work with PTSD and the limbic system (1994,

1996), and Prescott's (1995) studies of the trauma of insufficient maternal-infant bonding all receive support from the results of this study. The participants demonstrated that very early trauma may somehow be stored in the bodymind, expressed in psychosomatic conditions through adulthood, and then accessed for purposes of resolution. Wade's (1996) premise that neonates utilize co-existing and overlapping types of consciousness can be viewed throughout the testimony of the participants as they (a) demonstrate fetal consciousness by having awareness of their bodily experience, and (b) exhibit transcendent consciousness with a mature understanding of their situation, and the attitudes and feelings of those around them. Some of the healing reported by the participants in the current study such as the cure of headaches and the alleviation of depression and suicidality were also reported by the participants in Ruch's (1986) investigation. Interviewees saw working through birth and related phenomena as an important element in the self-healing process. On many occasions emotional and somatic problems such as headaches, depression and even suicidal ideation improved or disappeared altogether. (Wade, 1996, abstract, p. iii) Grof (1985) reports, "Difficult emotional and psychosomatic symptoms that could not be resolved on the biographical or perinatal level disappear or are considerably mitigated when the subject confronts various embryonic traumas" (Grof, 1985, p. 354). Janov (1983) lists many physical and psychological afflictions he believes to stem from birth such as, asthma, angina, migraines, pnigerophobia (fear of being smothered), and sexual dysfunction, which mirror the reports of the participants of this study. Avid complaints were voiced by participants with regard to medical intervention. These involved, forceps deliveries, anesthesia during labor, surgery without anesthesia (transfusion), and inversion at birth. Feeling unwanted or rejected, and not being allowed to bond with their mothers were the most painful psychological factors reported. Ruch (1986) once again confirms the findings. The most frequently mentioned disturbances were medical interventions, unforeseen complications and psychological difficulties. "The more the mother-baby relationship is disturbed at birth, the greater the likelihood that this bond of reciprocal responsiveness is stretched to the breaking point" (Ruch, 1986, abstract, p. iii). The distress felt by a neonate after technological intervention was reflected by Marisa (anesthesia, forceps), Douglas (anesthesia, forceps), and Caroline (anesthesia, transfusion, surgery without anesthesia). The possible long-term effects of such intervention were indicated by conditions such as migraine headaches, syncope, phobias, arthritis, and depression which lessened or disappeared upon the reliving of these events. Using "non-ordinary states of consciousness" in psychotherapy, Stanislav Grof has formed conclusions that are directly supported by the experiences of the participants in this study. The protocols of Marisa, Douglas, Rachel, Caroline, Amy, and Jesse reflect the healing of emotional and psychosomatic conditions after revisiting prenatal and perinatal trauma. Grof (1985) frequently refers to the strong possibilities of symptom alleviation through the remembrance of trauma on all levels of the prenatal and perinatal period. Many of the terms used by Grof (1985, p. 112-116) to describe the suffering felt by laboring prenatals in his Basic Perinatal Matrices II and III are replete in the protocols of Rachel, Douglas, Karlton, and Caroline. References to feelings of being crushed, trapped, suffocated, panic stricken, and of dying can be found throughout. One remarkable difference between these protocols and Grof's BPM TV, however, is that none of his descriptions of the enormous relief felt by the newborn upon the resolution of labor and delivery are mentioned by the participants of this study. While one could postulate that the remembrances of the participants were merely a matter of backwards projection, that is, memories, attitudes or suppositions formed in childhood or later, and then projected backwards onto their prenatal and perinatal experience, the veridical recordings of the movements of birthing infants painstakingly recorded by Cheek (1974, 1975) give rise to considerable doubt of that idea when used in conjunction with Karlton's description of certain head pressures, movements, and bodily changes during the remembrance of his birth. The possibility of having been unduly influenced by what he had read notwithstanding, Karlton felt that his reenactment closely resembled the description of a birthing infant's movements taught by Emerson (1978, 1987, 1998). Further, Grof (1985) and Janov (1983) give descriptions of the rigors of the reenactment of birth that closely resemble the trauma described by Douglas, Karlton, Marisa, Caroline, and Rachel. Salk, Lipsitt, Sturmer, Reilly, and Levat (1985)

correlated the factor of respiratory distress for more than 1 hour at birth significantly with subsequently elevated suicide rates in adolescence, suggesting that events occurring during labor may remain indelibly imprinted on the mind. As such, Douglas' and Marisa's suicidal tendency after suffering asphyxia at birth could be linked with this finding. Conclusions from Khamsi's (1987) doctoral study, phenomenologically examining birth feelings among participants in primal therapy, can be seen to match conclusions drawn from the current study. "Most subjects felt they were born with feelings, some sense of the self, and an ability to think" (p. 55). CONCLUSION I am satisfied that this phenomenological investigation has both confirmed past research and contributed to the field in new ways. Renditions of the data and testimony of the participants point to the reality of prenatal and perinatal memory and consciousness. Further, the outcome of accessing that memory, however anguishing the content, can manifest as profound healing. The fact that the current investigation focused on life-changing, symptom alleviation as a result of the remembrance of prenatal and perinatal experience, and it revealed unanimous trauma, despair, physical injury, and child abuse or neglect, suggests that overt symptom resolution from prenatal and perinatal recall may be the result of especially traumatic prenatal and perinatal experience. This suggestion coupled with the results of other studies indicates that the roots of some diseases, both psychological and physical, may go beyond genetics, to the prenatal and perinatal or transpersonal realms of consciousness (Grof, 1972, 1985; Janov, 1983; Ruch, 1986). Since the etiology of disease may reach into the prenatal and perinatal realms, a greater focus must be made on how that aspect of life is handled by parents, physicians, and others in the medical field. The study's examination of obstetric intervention and the illumination of the experience of receiving it, suggests that kinder, more thoughtful systems of birthing children are called for (Grof, 1985; Leboyer, 1976). Greater awareness of and research into the natural rhythms between mothers and babies could result in less traumatic birth, hopefully reducing long-term, pathological outcomes. Studies on the short- and long-term impact of medical intervention on mothers and babies is vital. Further, the education of expectant parents on the options available to them and the risks involved in obstetric interventions, such as ultrasound, anesthesia, vacuum extraction, or circumcision could lead to more informed decision making, and a less destructive impact on the fetus and neonate. Last but not least are the profound possibilities for healing that this research presents. The possibility of finding cures or alleviating such conditions as asthma, phobia, migraines, syncope, visual impairment, and depression is impressive if not daunting. If more research is conducted that can demonstrate the depth of healing available through the unconscious mind, the taboo surrounding it could be mitigated as well.

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**Publication title:** Journal of Prenatal & Perinatal Psychology & Health

**Volume:** 15

**Issue:** 2

**Pages:** 146-172

**Number of pages:** 27

**Publication year:** 2000

**Publication date:** Winter 2000

**Year:** 2000

**Publisher:** Association for Pre&Perinatal Psychology and Health

**Place of publication:** Forestville

**Country of publication:** United States

**Journal subject:** Medical Sciences--Obstetrics And Gynecology, Psychology, Birth Control

**ISSN:** 10978003

**Source type:** Scholarly Journals

**Language of publication:** English

**Document type:** General Information

**ProQuest document ID:** 198695349

**Document URL:** <http://search.proquest.com/docview/198695349?accountid=36557>

**Copyright:** Copyright Association for Pre&Perinatal Psychology and Health Winter 2000

**Last updated:** 2010-06-06

**Database:** ProQuest Public Health

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