The Early Root of Trauma

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Abstract**:** The author's research, the aim of which was to try to establish the actual facts of unconscious memory, succeeded in finding that such memories do exist and are the root of a wide variety of mental health problems. The research also, unexpectedly, identified a basic instinct for survival and revealed a deep-rooted suspicion of a mother's love as the vehicle which carries the suffering of infantile trauma through childhood mental health problems to the adult's irrational and sometimes violent behavior.

Keywords: birth memory, bonding, prenatal, trauma

The findings which form the basis of this paper originally resulted from research conducted in the United Kingdom (UK) between 1986 and 1995. It was published internationally (Gorman, 1997) but neither I, nor it seems, any reader of that article realized the full significance of the findings. It has taken observation of the more recent UK rise in mental health issues in the young and the increase in irrational and violent behavior among adults for the full import of those findings to be recognized.

A. Graham Gorman, ADHP(NC), MNRHP, UKCP (Ret'd) DFH(Hons.), C. Eng., FIET (or Tony as he was known during his first career) graduated in electronics engineering science and physics in 1946 and then had a forty year career in the international electronics industry, with a leaning towards computers, communications, and related personal safety products such as flying helmets. He received two Queen's Awards for contributions to technology. A complementary interest in medical science caused Graham to see some parallels between computers and the human brain. As a result he retired early from his technical directorships in an international electronics group, requalified suitably and began his ten year research into the vexing question of unconscious memory. Graham's engineering background has influenced his attitude to his research. He says, "We engineers like to know how things work, down to the last nut and bolt." His results reflect that. Graham now spends such time as he can writing articles and giving talks on his own findings about infantile trauma. Graham has been married for 63 years and has four children, seven grandchildren six great grandchildren.

The research used hypno-regression techniques to explore the research subjects' possibly buried memories. This author made one biased assumption, that any veridical unconscious memories would most likely be associated with past traumatic events. So, subjects were chosen from individuals who had presented to my hypnotherapy practice, the main purpose of which was to conduct this research. (The remainder of the 1,200 total clients were treated as appropriate.) Every care was taken to use "clean" language and open questions and no suggestion was ever made as to the possible cause of a subject's problem. I strongly adhere to Milton Erikson's often stated dictum, "The only person who knows the cause of his problem is the person who has the problem." I would add to this, "But he doesn't know that he knows."

The research group consisted of a total of 404 adult subjects, 48% female and 52% male, and with ages ranging from 18-70 years. This large number of subjects arose because I wanted to check how many different presenting symptoms might have any root in any unconscious memories. Further, a distinction between home and hospital birth, which emerged during the research, benefitted from a sufficient sample of each to ensure the comparison had statistical validity.

This article will concentrate on the findings from the research and will describe the method details only briefly.

Method

An initial consultation served to confirm the subjects' suitability for hypno-regression and to discuss their family relationships, as few neuroses exist in isolation.

The second session was devoted to obtaining, while under hypnosis, a "trauma scan," a chronological list of those past experiences that might be the precipitating factor in current problems. Subjects were introduced to the ideo-motor response technique (Cheek & Le Cron, 1968) and they indeed lifted a chosen finger to indicate each age at which a relevant event had occurred. This scan was continued from their current age down to birth, and as many subjects were responding at that age, the scan was continued down through their gestation period to one month after conception. A surprising number of subjects responded at these early times.

In subsequent sessions, subjects were regressed to the declared ages to identify and re-experience the indicated traumas. An engaging scenario was created for the journey back through their ages and the subsequent concentration on each scene as they travelled through it, serving as a very effective trance-deepening technique, such that most subjects dissociated, especially at the earliest memories, as they re-experienced the reality of the events.

Independent corroboration is the only obvious way of establishing whether any recovered memories are essentially factual, or false for

whatever reason. In forty-five cases, memories were successfully confirmed by post-research waking state interviews with the subjects' mothers. Not only were the subjects' recalls confirmed, indeed, they were done so in amazing detail. Only corroborations up to the subjects' preverbal stages were accepted, to minimize the effect of later contamination by family reminiscences.

The great majority of the subjects' original interpretations of the earliest events turned out to be entirely mistaken and, as I discuss below, this had affected their whole lives. It was therefore essential, when the subjects returned from dissociation, to have their adult minds understand the irrationality of their original perceptions. This often proved to have long-term benefits.

To confirm the long-term effect of resolving the presenting traumas, effort was made to contact all subjects at one year after completion of their time in the research. If they had no recurrence of their presenting symptoms, no transference to alternative symptoms, and could describe themselves as relaxed, confident, and content, they were recorded as successes resulting from the therapeutic effect of resolving the unconscious traumas.

Results

Later-recalled life events, which were termed "secondary traumas," may have only occurred because the first, "primary trauma," had occurred. These later events were perceived repeats of primary trauma and confirmed the original fear of abandonment. It is therefore logical to record the results chronologically from the one-month post-conception traumas. (Other workers, e.g. Emerson (1996), have noted the basis of these later traumas, sometimes termed "interactional" traumas.)

Note that in the following results, all verbal statements quoted from subjects were made whilst in hypnosis.

One Month Post-Conception Traumas

Twenty-six subjects indicated trauma at this age. Their abreactions were intense, both physically and verbally. All the subjects had experienced a threat to their continued existence and screamed about the unbearable burning pain. They variously writhed about, punched the air, and shouted their anger and their hate of mother, in very basic language. Such phrases as, "Why don't you want me?"; "What's wrong with me?"; "I must have hurt you."; "I hate you, you f-----g b---h." The manner and the ferocity of these abreactions seemed more animal than human as they expressed their terror at the perceived threat of impending extinction. They were apparently revealing a very basic instinct for survival.

Later interviews with the mothers in all of the ten check-ins related to this age that were deemed worthy of confidence revealed that their pregnancies had not been planned and definitely were not wanted. The mothers had been both fearful and angry and several had wished they could abort. So, the recovered memories did seem to be of a genuine and threatening event. One subject recalled a very hot sensation and strange noises and a series of disturbances to his environment. As he returned from dissociation but still in deep trance he claimed that mother was in a hot bath and drinking a bottle of vodka "to get rid of me." His mother stated that her pregnancy was accidental and very unwanted. A friend had suggested that she take a hot bath and drink a bottle of liquid paraffin. She became very ill but did not abort the baby. This subject's recall was an example of how the relating of a recovered memory can be tainted by the subject's possibly incorrect assumptions, while remaining essentially factual.

The full significance of the universal blaming of mother for the trauma only became apparent as the research progressed.

Later Intra-Womb Primary Traumas

Forty-three subjects declared their first relevant memory at various months during mother's pregnancy. The causes were mainly illness, accident, or family discord, anything that had stressed the mother. Again, the abreactions were intense and, again, the mothers were accused of not wanting them. In one case, the mother was an avid tennis player and horse rider. She had not wanted to give up her sport until shortly before the birth. The fetus sensed that mother was trying to throw it out.

Birth Traumas

A surprising number of 365 subjects, out of the 404, declared a first trauma at birth. It was the modal age for suffering a primary trauma and it far outweighed the incidence of traumas at any other age. Typical situations that had caused birth trauma in my subjects were: a Cesarean birth; very slow or quick birth; umbilical cord cut before baby had taken its first breath or been laid at mother's breast; use of forceps or a ventouse; being taken away immediately after birth for suctioning, washing, checking, and weighing before return to mother; adverse comments they had heard; bright lighting; and being removed to a nursery except for feeding times.

The abreactions were again intense and the recalled detail was remarkable. One subject recalled lying in a small cot and trying to learn to move his arms to shade his eyes from very bright lighting. His mother later confirmed he had been in a bassinet and he screamed and waved his arms about; she also said the lighting in the room was very bright. Another recalled her mother crying out, "Oh my God, look at her face."

The adult subject had a large red birthmark entirely covering one cheek. Yet another, having been whipped away from mother immediately after birth and being held by a nurse, whispered, "Perhaps this one will look after me." A subject who had been moved to a nursery, called out, "I've been put here to die like all the other babies I can hear crying."

Every trauma recall expressed the fear of abandonment by mother, with the associated anger, but also feelings of worthlessness. "I can't be good enough for you, mother" was one example. Another reaction was, "I didn't ask to be born so I deserve to be loved." One subject, being returned to mother after the common postnatal separation, murmured, "You seem to love me but can I trust you?" This, in spite of mother, as she later confirmed, having given her baby the loving welcome that most mums do.

It is notable that the procedural causes of birth trauma are those most commonly associated with hospital birth. Three-hundred-and-thirty-nine subjects had been born in hospital and 83% had suffered their primary trauma there. By comparison, of the sixty-five subjects born at home, only 22% had suffered a primary birth trauma. Indeed, thirty-nine home-born subjects only suffered their primary trauma during their first year after birth. The causes included illness or death of mother; violence from the father; and parents' divorce. Detailed figures are summarized in the following table of primary trauma incidence. All the subjects who had suffered intrawomb trauma inevitably suffered a secondary trauma during birth, so the intrawomb primary traumas add to the primary birth traumas to reveal the total percentage of traumatized postnatal infants.

PRIMARY TRAUMA INCIDENCE		
TRAUMA OCCURRENCE	HOSPITAL-BORN	HOME-BORN
Intra-womb 4wks	22 (6.5%)	4 (6.2%)
Intra-womb, later	35 (10.3%)	8 (12.3%)
Intra-womb, total	57 (16.8%)	12 (18.5%)
Birth, primary	282 (83%)	14 (22%)
1st Year Primary	0	39 (60%)
Total	339	65
Total Subjects	404	

Secondary Traumas

These were the events that subjects had identified between their birth and their current age during the initial trauma scan. The abreactions were not so intense, but nevertheless, were filled with emotion, some anger, and occasional tears. Typical causes included: birth of a sibling; sent to nursery school; mother starting to work; mother hospitalized;

starting school; changing school; sent to boarding school; leaving home for university; and parents' divorce.

All of the external causes were related to real or perceived separation from mother. The events had triggered the original abandonment fear and, so, resulted in the secondary traumas.

The theme extended into adulthood and with more problematic outcomes. At puberty, the suspicion over the sincerity of mother's love had extended to all women. This affected both sexes, but was more significant in men. One male subject declared, "You can't trust women. They only pretend to love you."

One male subject had suffered trauma during a hospital birth, mostly due to an extended separation from mother immediately after birth. At three years old he was sent away to an aunt while mother gave birth to a sibling. The boy was returned home to coincide with the homecoming of the baby. As we regressed to their first meeting he recalled being expected to kiss the baby. He hissed, "I want to kill it" and was very distressed. His behavior deteriorated and when he eventually started school he suffered considerably and invented many reasons for not going. At puberty, at age fourteen, he soon started having sexual relations with girls. At age twenty-five when he presented for therapy, he had not had the confidence to leave home. He was visiting bars nightly to pick up a woman only for sex. He came to me after being rejected by a woman with whom he had maintained a longer relationship and he was clinically depressed. In hypnosis, having regressed to a particular assignation, he muttered, 'This one loves me but what about all the others?" The unconscious, being irrational, is not satisfied by a single expression of love. It seemingly cannot generalize the reassurance.

Trigger Traumas

A particularly relevant event that reminded subjects forcefully of the primary trauma was subsequently labelled a "trigger trauma." Trigger traumas produced obvious and significant mental health problems. There were 404 examples that had presented to this author's practice. They presented with nearly ninety different problems.

Examples of trigger traumas were: loss of a parent, close relative, or partner; leaving home; rejection by partner; loss of job; giving birth; and potentially fatal incident.

The most frequent presenting problems by a large margin were: depression, anxiety, low confidence, and agoraphobia.

Summary of New Findings

1) Veridical unconscious memories do seem to exist as corroborated by a total of forty-five waking state interviews with the subjects' mothers. A further eleven interviews with mothers also confirmed the subjects' recalls but I was not convinced that family reminiscences might not have influenced the recalls. The recovered memories of the remaining 359 subjects were similarly rooted in the deep suspicion over mother's love and so it is at least likely they were also veridical memories. These unconscious memories are however not contained in our human memory system as it is normally defined and studied by psychologists. Their characteristics together with the early stage of the baby's development at which they occur suggest that they exist in the reptilian hind brain we have inherited through evolution. Considering the four week post-conception memories, they surely can only be cellular memories.
2) A basic-level instinct for survival is suggested by the embryo's one month post-conception intense reactions to perceived threats to life.
3) Whatever the external cause of infantile trauma, the universal response of the prenate seems to be to blame mother for the threat of extinction. This threat to the intense urge to a continued life results in anger and hatred of mother and a resulting long-lasting suspicion about the sincerity of mother's love. It is revealed as the vehicle that carries the irrational doubt of mother's love through childhood to adulthood and on to the adult's irrational fears and behaviors. Alarmingly, this suspicion spreads to all women at the individual's puberty.
4) The hospitalization of birth appears to be a factor in the incidence of trauma to the prenates and infants.
5) It surely follows from the progression of prenatal traumas through to adult behaviors, as confirmed by my subjects, that the unconscious is psychodynamic.

Discussion

This research is by no means the first to recover unconscious memories. Early workers were Lake (1966) and Grof (1975), who both used LSD to achieve memory recovery until its use was banned, and Cheek (1968) was writing about age regression in hypnosis. German, Paul Bick (in Verny, 1981) also found prenatal traumas. In most cases though, there is little or no evidence that these memories have been independently corroborated. A notable exception is David Chamberlain's evidence from mother and child pairs (1986). More recent writers (Newton, 1994; 2010; Levine, 2015), using their own unique approaches, have contributed

substantially to the techniques for reducing the impact of traumatic memories.

It is important to note that all of the afore-quoted recalled memories cited in this article have been independently corroborated. The vast majority of the prenate's primary perceptions as reported in the therapeutic sessions forming the basis for this research turned out to be mistaken and irrational as almost all mothers sincerely love their babies. Therein lurks the terrible, possibly lifelong consequences, of primary trauma. We can begin to understand this initial reaction if we consider the situation of a developing baby inside its mother's womb. The embryo or fetus presumably has no knowledge or experience of any environment outside of its current one. It apparently senses, at whatever primitive level, that some force is its provider of life. When adults who have been regressed to prenatal trauma return from dissociation, but are still in a deep trance, they identify that "force" as the mother. That is when they begin to express their anger and the resulting hate for the presumed rejection with its threat to their continuing existence.

The revealing of an apparent instinct for survival at just four weeks after conception was entirely unexpected. The violence of the reaction to these very early post-conception memories also implied that this early start to a human being had an immense urge to survive. Instincts have historically had minimal acceptance as being any characteristic of a human being. My subjects' abreactions suggest we are far more primal than we have been humble enough to admit. I suggest it is also logical that an instinct for survival might be the earliest asset to acquire. There would not be much point in it developing at some later stage; we might have fallen prey to some unrecognized threat by then. This would not comply with nature's aim for every species that it should survive and proliferate, which requires survival at least to reproducing age and nurturing period. This instinct is obviously operating at a very basic cellular level. Bruce Lipton (2005/2015), a cellular biologist, has reported that a cell membrane exhibits the characteristics of a computer processor and that the cell also contains a memory capability.

The subjects' identification that anger with mother was the universal response of the infant to any and all external causes of prenatal and perinatal trauma was very specific. It accords with the reduction in child/mother bonding of traumatized babies already widely observed. It also explains the core of the process by which infantile trauma is perpetuated in adults' mental health problems. The relationship between adults' unsociable behaviors and problematic childhoods has, of course, long been recognized but the exact nature of the process by which the details of the adult's behaviors are specifically dependent on the detail of the infantile trauma is a finding apparently unique to this research.

The medicalization and hospitalization of the natural process of birth giving seemed to contribute to serious consequences for my subjects. Many professionals are obsessed with abuse of children and especially sexual abuse, as the major cause of trauma of the young. But, happily, it is only a small minority of families who abuse their young in any way. By comparison, the majority of hospital-born subjects in my research group, left hospital severely traumatized. Hospital birth seems to be a major contributor to infantile trauma. In the UK, since about 1975, over 98% of babies have been hospital born compared with about 40% in 1945. Marjorie Tew (1998), formerly a research statistician at a UK university medical school, proved by the UK Government's own figures, that UK hospital-birthing was less safe than home-birthing, except when there were pre-evident complications. Michel Odent (2002), a French obstetrician, has been writing since 1986 about the many unfortunate outcomes of modern birthing methods. The levels of birth trauma in my subjects are not necessarily relevant to the general population as all my subjects had presented for therapy. However, since 1985 in the UK, the level of elective Cesarean births has risen to 30% and the number of very premature babies treated at length in hospital units has risen considerably. In society, the rate of irrational crimes such as stalking of a female ex-partner, murder of such a partner, and murder of the partnership's baby, increased from 1.6 million in 1970, to 4.4 million in 1990. Just one year later, the number had reached 5.3 million. Few outcomes stem from a single cause. However, we do need to consider the hospital practices that may be contributing to traumatic birth experiences and, possibly, to later criminal behaviors.

Closing

In regressing subjects back to prenatal experiences, this research seems to have produced more detailed information about the internal reaction of the embryo and fetus to external trauma. While a certainty about how these results were produced is not possible, they may partially stem from the policy of first obtaining a chronological trauma-scan, then regressing to what turned out to be the secondary traumas, before approaching the primary trauma. This may have enlightened the subjects to the involvement of mother in their presenting problems. Further, the trance-deepening technique used during the regressions possibly contributed to the fact that subjects dissociated and actually relived the traumatic experiences. Creating a safe place was essential so that subjects felt completely safe during their dissociations. As a number of the recalls were reliably corroborated, it is unlikely that they were fantasies.

Investigations and research into the effects of infantile trauma and the connections with adult outcomes have necessarily been observational. We can note the results, and some of the early causes, and hope that our

conclusions are correct. The detailed insights achieved by these subjects have enabled the babies to speak for themselves. And they have given us some hitherto-unknown information.

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