

Psychological Treatment of Birth Trauma With Age Regression and Its Relationship to Chemical Dependency

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Publication info: Pre- and Peri-natal Psychology Journal 1. 2 (Winter 1986): 111-134.

[ProQuest document link](#)

Abstract: None available.

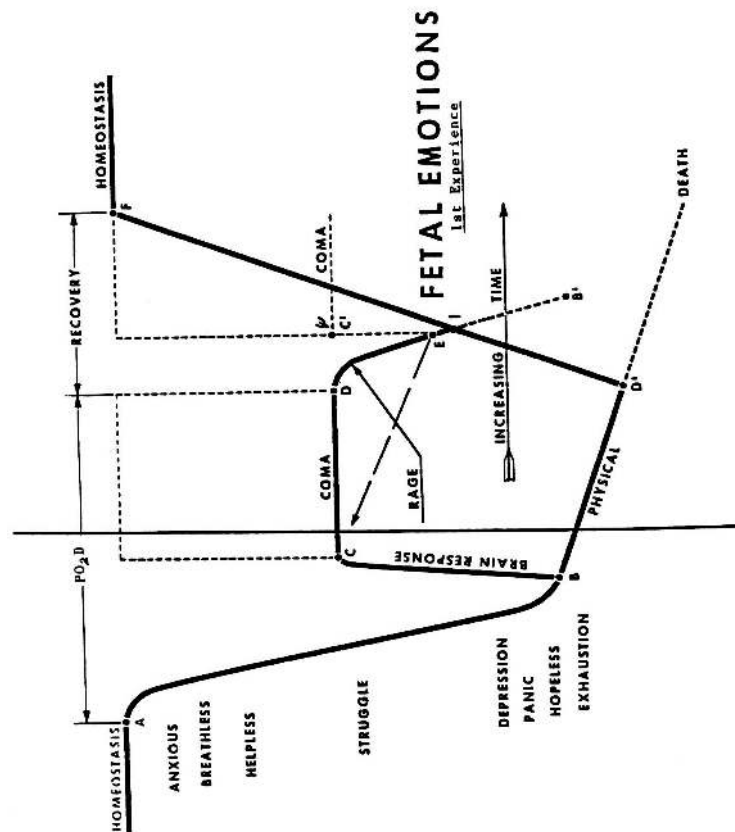
Full Text: The purpose of this paper is twofold; first, to provide some understanding of a very severe birth trauma which, until recently, was unrecognized and therefore untreated psychologically; and second, to provide insight into a method of treatment. There are many occurrences which cause trauma by or before the time of birth. The one, above all others, that causes severe trauma relates to oxygen deprivation which can occur presumably at any time during pregnancy. It happens most often in the third trimester and particularly as term approaches. The mother's ability to supply oxygen to the fetus becomes marginal as the fetus grows and its need for oxygen increases. Concurrently, the placenta grows and its need for oxygen also increases. Since the placenta is interposed between mother and the fetus, the placenta draws its need first, and the remaining oxygen goes to the fetus. Even under normal conditions, the fetus has little to spare by the time of birth. There are both physical and emotional causes of oxygen deprivation. (Listed on page 131.) Fetal oxygen deprivation represents a primary problem in the world today. We can support a probability of 20-30% of all babies having experienced it to a severe degree, but short of any material amount of brain damage. Some authorities rate this occurrence at over 50%. A physician who delivers babies in a poverty area stated that he observed meconium in amniotic fluid occurring in 50-60% of deliveries. Since the baby does not eat, there is no physical need for it to have a bowel movement; however, it is a well known fact that sudden powerful fear may cause the bowels to move, even in the fetus.^{1,3,6,10,16} A normal baby has its problems, but they are minor compared to those resulting from PRENATAL SUFFOCATION.^{11,19} If oxygen deprivation is severe enough to cause loss of consciousness, then a precise pattern of emotionality will result. The following seven symptoms are part and parcel of what I have named the Prenatal Suffocation Syndrome (PSS): Breathlessness Helplessness Panic Depression Hopelessness Exhaustion Rage There are other emotions related to PSS, but they are not always present and so do not fall within the specifications of "syndrome," some of which are: rejection, loneliness, claustrophobia, agorophobia, and a need to get "away from" (where ever one may happen to be). This need to get "away from" is not concerned with going to any particular place, just away from. Importance of Prenatal Suffocation Syndrome (PSS) There are four identifiable problems, in which PSS is a causative factor, or perhaps even the prime cause. These are: 1. Borderline schizophrenia, 2. Alcohol abuse, 3. Drug abuse, and 4. "Nervous Breakdown." 1. Throughout my years of practice, I have worked with a number of patients who had spent time in mental hospitals, and had been labeled Schizophrenic. All, without exception, demonstrated PSS. Those people had extreme FEAR-of FEAR ITSELF. They panicked at the prospect of becoming fearful. Borderline schizophrenics are those who have not developed a sufficient loss of contact with environment and disintegration of personality deserving the classification of schizophrenia. They are very difficult to treat as patients; because they are so very fearful of the thought of suffocation, anticipation of something unknown may trigger their escape mechanism, and they will make every effort to avoid therapy because the thought of getting into their feelings is seemingly more than they can stand.^{2,8,15} 2. and 3. Alcohol and Drug Abuse: The compulsion which motivates excessive use of these agents relates to the need to escape: to escape the feelings induced by prenatal oxygen deprivation. By inducing blackout and or/unconsciousness, drugs (including alcohol) provide this escape. In order to understand how drugs provide "escape," it is necessary to understand why the user needs to escape. This action will be more fully discussed later in the text.⁷⁻²⁰⁻²¹ 4. "Nervous Breakdown" has been placed within quotation marks because it is an "emotional breakdown." It is a

demonstrable, integral part of PSS.²³ Because of the overwhelming impact of the PSS, these feelings will supercede the feelings of any other traumatic event which becomes associated with it. As you will see later, there are a great many of those who have suffered PSS who live their life-time being nervous-actually, afraid to feel good. Such people call "good" just not feeling noticeably nervous. In working with these people, it is of paramount importance to help them see and understand the part of their emotional continuum they have avoided throughout their life-time, and why they have done so. The dystonic feelings become both "cause" and "effect," and later in life will generalize widely, in contrast to phobias, making it possible for these victims to have seemingly hysterical reactions to a great many different, and apparently unrelated, events.^{18,22} I believe the origins of "nervous breakdown" and psychosis, and the difference between them will become apparent when psychosis is discussed later in this text.

Prenatal Suffocation Syndrome The fetus has no words, so its thoughts are entirely related to its feelings, emotional and/or physical. It can "like" or "not like" whatever it feels, and draw such "conclusions." One day before birth, it is as capable of thought as it is one day after birth. No doubt, however, it has more experience in thought processing after birth. In the event of oxygen deprivation, the fetal emotions occur in a precise pattern. The charts to which I will be referring are not theoretical. They compile the experiences of over two hundred patients who have given me their reactions while reliving their prenatal oxygen deprivation. I have plotted the summation of their responses in as simple a form as I can deduce. I have found them to be useful in helping the patient to understand the problem. In order to treat this stress problem, it is essential for the therapist to understand what the patient experienced as a fetus. My method of dealing with this very difficult emotional problem has been named **INDUCTIVE THERAPY**. This is the first that has been written about it, but I hope you will be hearing a lot more in the future. In a basic sense, it is Freudian. It was he who first recognized the need to find the cause in order to solve a problem. But, that is only part of the solution. The experience must be relived by the patient in order to know, not just believe, what caused his/her feelings originally. The brain is capable of reliving any experience within its life-time. This is, of course, the very basis of our "problems." The act of suppression occurs because we may feel bad-anger, fear, guilt, shame, etc.- whenever we think of what happened. So in order not to feel bad, we "forget" the incident. Then we block it out-repression-and our problem is solved. We don't feel that way any more. Too bad it doesn't stay that way! We have blocked out the action but not the reaction. Later in life, something similar to this "blocked out action" sets up an associative impulse strong enough to break through the block. Though the "action" is stimulated, it does not get back into consciousness, because the block is stronger in this direction than in the other. However, the action having been stimulated, the reaction is also stimulated. The reaction is not blocked, so it comes out and we feel now as we felt then. Being unaware of the old action, and feeling the old reaction again, we have a strong tendency to attribute it to the new action. When we accept the mistaken idea that this old reaction is our new reaction, it becomes our motivation to behave toward the new action. This is the manner in which we deceive ourselves into unreasonable behavior, simply an over-reaction to our current problem(s). Treatment in **INDUCTIVE THERAPY** relates to over-reactions (feelings and emotions) which cause the patient to have problems. The therapist recognizes the unreasonable emotion(s) and gets the patient to re-experience, to feel the emotion, and then identify its components, such as shame, guilt, fear, anger, sadness, crying, etc. It is important to identify the elements before beginning regression, because the incident to be uncovered by the patient must account for each and every one of them. Place the patient into deep concentration-actually a medium state of hypnosis. Having identified the feeling(s) specifically, let the patient relax and let the feeling(s) disappear. Make sure the patient lets them go completely. Instruct the patient that when you have caused them to have a feeling, they will always be able to let it disappear whenever you tell him/her to let it go. On the basis that nearly all traumata occur before 20 years of age, regress the patient to 20 years of age. Suggest: "If you have ever felt this particular feeling (nervous, rage, fear, or whatever the feeling is you are tracing), you will be able to feel it again now. Try to feel it." If the patient does feel it, let it disappear again and relax (the patient, not you). If the patient does not feel it, then start back up: 21, 22, etc. until the patient begins to feel it, or gets back

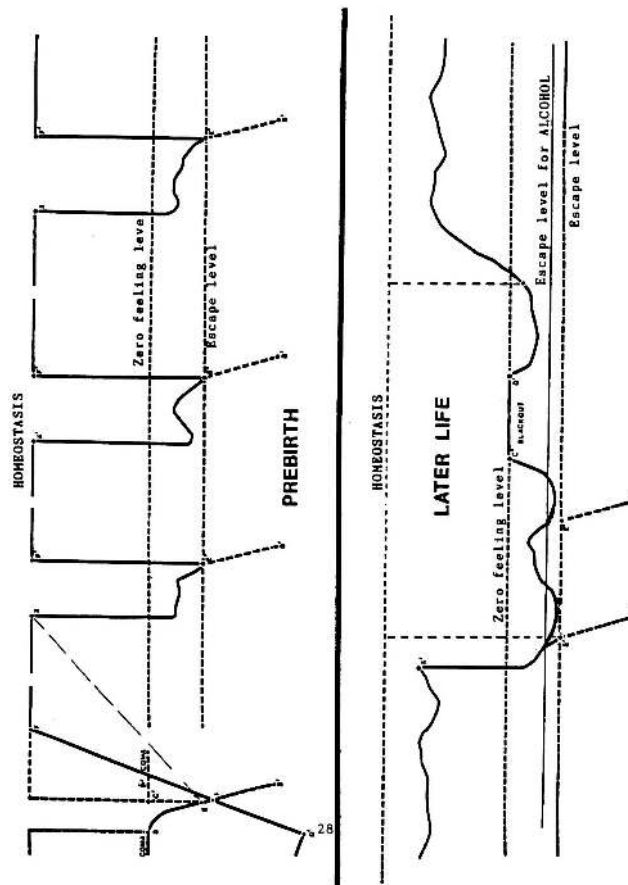
to an age level older than that at which it was felt before. If this should happen, you simply explain that the patient is not concentrating and go back to 20 again. It is quite possible the patient may now feel the emotions. If not, start 21, 22, until the patient feels it. Then get them to relive the incident they think about. If this incident doesn't account for all the feelings, go back to 20 again and the patient will probably feel it. If so, continue the regression. The content of the incident will clue you as to its legitimacy. When the patient has an idea about an incident they think is the reason for their problem, they may take you to that incident. Seldom is this the true cause. Patients can never consciously recall what caused the problem. But it often pays to humor them and point out the discrepancies between the emotions in the recovered incident and the emotions you are tracing. Usually then the patient will begin to let you lead and you can move on. With the patient again relaxed and relieved of the emotion, regress to 10 years of age. If the patient feels it, let it disappear and regress to 5 or 1 (use your own judgment as to how many years you wish to move in one step). You must continue regression until the patient is unable to feel the emotion(s) being traced. Do not hesitate to suggest or simulate any idea you might think would stimulate your patient to respond with the feeling. Remember, if the patient has not had an experience, he/she cannot have a feeling. No amount of suggestion can cause feelings. We come into this world with the ability to feel, but we do not feel until or unless something happens. There is a big difference between feeling and imagination. We can imagine almost anything, but, you cannot feel anything unless you have had an experience to cause it. All we are interested in during regression is the specified feeling and no other. We are not interested in incidents the patient may recall or think about during the regression. You may make note of anything you think might be pertinent and you can come back to it later. Don't let your patient digress from the emotion you are tracing. In the event the emotion traces on back to birth, and it is still there, say "go back before the time of your birth, back within the womb," and then take them on back to a time a little before the patient has ever felt this feeling. Get the individual back to homeostasis. This follows the principle of regressing to a time prior to the experience, and then we come up to the point in time when the feeling(s) begin. There are exceptions, but usually when feelings trace to birth or before, they will relate to oxygen deprivation. This is the problem I'll concentrate on and you may question me on other problems during the question and answer period. Start talking to your patient about being trapped, helpless, getting harder and harder to breathe, getting weaker and weaker, more and more depressed, anything you can think of to stimulate these feelings. It is often helpful to put your arms across the patient's body, pulling their arm tight against the body-talk about being trapped, can't get out, can't get away, etc. Also you can apply a little pressure to the patient's chest by leaning on him/her slightly, along with the suggestions that it is getting harder to breathe. The idea that it is getting hard to breathe can also be stimulated by cupping your hand over the patient's nose and mouth, sometimes with slight pressure against one side of the nose. You will quickly learn how to do this without actually blocking the breathing at all. The important thing is that your patient will feel as though he is unable to breathe despite the very obvious fact that breathing is occurring almost like hyper-ventilation. When you have stimulated the panic feeling as strongly as possible, begin to suggest the thought of dying, of slipping off into that dark black nothingness, just drifting off and away, etc. The patient will begin to calm down and stop breathing heavily. Talk to them about being back in that nice, calm peaceful floating feeling. This is the coma (feeling only, of course) that follows anoxemia. The fetus at this point doesn't feel "nothing at all" as you might have thought. During the time oxygen deprivation is happening, the fetus has been wanting to get back into the homeostasis feeling. Now that all of the terrible feelings of panic, depression, exhaustion, and hopelessness have disappeared-as consciousness is lost-the brain is not dead and it can have the homeostasis feeling from its own memory. It cannot tell the difference between memory and the original feeling, and it is as though it is back in the original state. Obviously, this is a delusion because it is closer to death in coma that it was when the feeling was so terrible. As you can see on chart #1, we have progressed from homeostasis to coma. Tell your patient, "We now move to the point where recovery begins. As oxygen begins to come back into your system your brain begins to recover and resume its functions, one of which is to monitor the condition of your body. So

you begin to feel a little anxious again, becoming more and more breathless. It's as if somebody or something is making you feel this again. You don't want to feel it. You want to stay the way you were and be left alone."



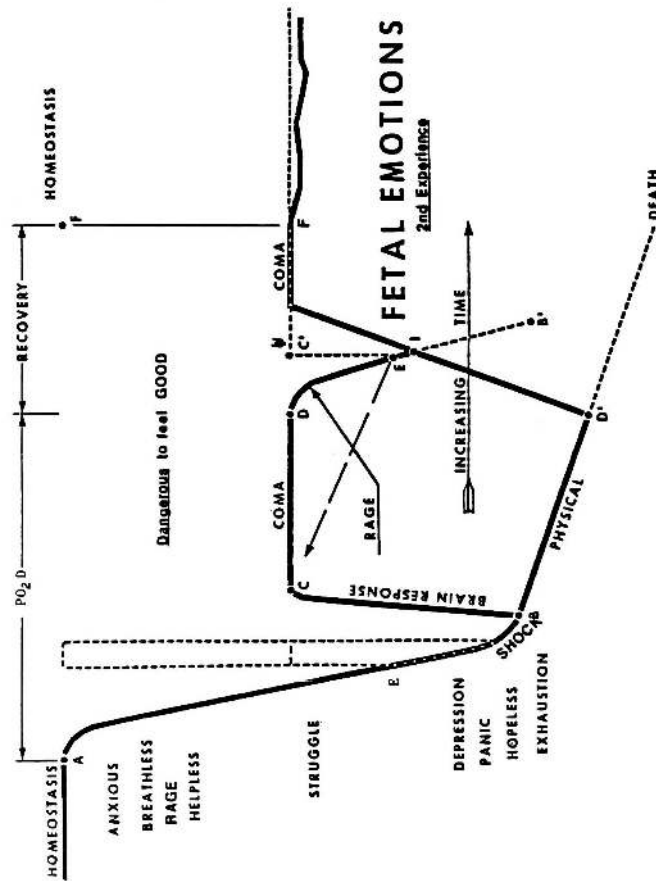
At this point, I take both the patient's wrists and move the arms up in front of the chest. I say repeatedly, "They're doing it again! They won't leave you alone!" etc., as I move their arms as if they were fighting or striking out at something. The object is to stimulate their rage. They don't want this to happen again. I usually continue this action in spite of their anger until suddenly they give up and go limp and relaxed. This means they have gone into the psychological coma and back to homeostasis in the same manner in which they thought they did when they actually lost consciousness. If the patient is stronger, and beginning to wear you out, begin to tell them, "You are becoming weak. It's going to happen again, etc. You have to give up and get out of this or you will lose control and the again." Keep up the talk and the struggle until they give up. The true loss of consciousness was an involuntary act but along with it is a sensation as if they "gave up." At point E on the chart, they give up because now it is as if it is happening and will be as it was before. Knowing they can't stand that, they become frantic to escape and the brain reproduces the condition (coma) which immediately followed the sensation of giving up. Now in the psychological coma, homeostasis is felt and sustained because the true feelings do not get bad enough to overcome the homeostasis feeling. The fetus is not aware of the moment true homeostasis is established, but allowing itself to "feel" again, nothing changes, so it is as if true homeostasis has been there from the moment they "gave up." This action seems to have provided escape, but not only that. "It" didn't happen as expected so it must be because of going into the psychological coma. The fetus takes credit for preventing it. The fetus now has control, it thinks, over the situation, and it knows what to do if should happen again. I will now finish the description of fetal reactions and I think you will be able to adopt your procedure accordingly to help your patient reexperience the events. The escape pattern, by inducing psychological coma, is now established and reinforced by what seemed to have been another occurrence of oxygen deprivation. Having been through recovery (falsely interpreted as another terrible experience) and

having been able to escape, the feelings recorded in the recovery portion of this initial event become "safe feelings" (D-E), unpleasant, but safe. These are the emotions which will be called "nervous" throughout the rest of the individual's life. Loss of consciousness during oxygen deprivation (true coma) is an involuntary act, but the refusal to be consciously aware (psychological coma) during recovery is a voluntary psychological reenactment of the true coma. The fetus does not recognize the difference between the true coma and the psychological coma. Therefore, the whole experience is falsely recorded in the brain as a first incident being reinforced by a second. Thus, the fetus comes to believe it has control over these feelings along with the ability to escape from them whenever they become unbearable. The "unbearable" feelings are those greater in magnitude than what is felt at point E when the psychological escape occurred. Since the unbearable feelings immediately precede the feeling of dying, they assume a causal relationship to dying. Later in life, the overwhelming fear of losing "control" is the direct result of this false impression. The individual is afraid to feel the "unbearable" feelings and avoids doing so, because the feeling of dying would follow immediately. This is fear of fear itself. Those things which occur together, at the same time and place, tend to become associated with each other. Just before the moment oxygen deprivation began at point A, the fetus experienced homeostasis. Just after that same moment, "something" happened, and the fetus became anxious. The same seemed to occur again as recovery began. Thus an association was established between homeostasis, something happening, and anxiousness. A short time after recovery is complete, see chart #2, the fetus begins to worry. It recalls that homeostasis is the way it felt when suffocation happened before. This thought associates to the conclusion that it is going to happen again as at B and the individual reverts to the safe, "nervous" feelings D-E. At this point, I again "fight" with the patient. (In all my experience, no patient has ever tried to hurt me. The rage is not directed at the therapist.) These psychosomatic feelings are a reflection of the recovery feelings. Once into the nervous feelings, the emotions will remain until they get bad enough to force escape again at the E level. The feelings will get worse, down to the E level, because the general progression during recovery was from D to E. The fetus becomes frantic to escape and gives up, as before, reverts to the psychological coma feeling, and thus back again to homeostasis. In as much as this seems to prevent "it" from happening, another reinforcement to the idea "the escape really works" has been provided. Since this response is psychosomatic, being induced only by the thought of "it" happening again, the response may or may not occur before birth, but it most certainly can and will happen in the years after birth. The positive reinforcement in these responses relates to the escape from "it" happening again. As far as the fetus is concerned, escaping from the intensity of the feelings below the escape level is an escape from dying, which for all practical purposes is what happened when true unconsciousness occurred. Since the feeling of dying was immediately preceded by the four distinct feelings of panic, depression, hopelessness, and exhaustion (the unbearable feelings), these emotions take on a causative relationship to dying. Throughout later life, this individual will avoid the feeling of dying (seeming to be an interference with the drive for survival) by avoiding these four feelings, convinced that if any one of them, any combination of them, or all of them together, is experienced, then dying will follow.



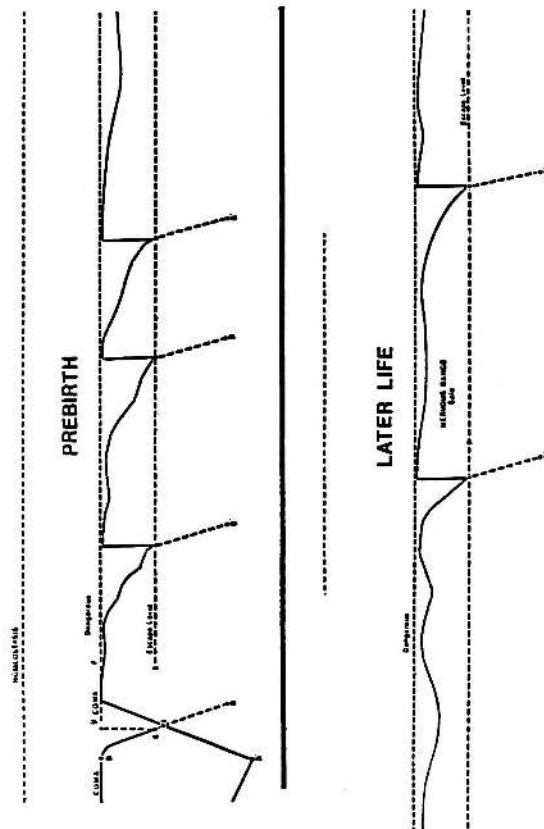
Feeling good, will after a short duration, become dangerous, because this is the way one feels when "it" (anoxemia) happens; the "nervous" feeling is experienced because it is safe, and if "it" does happen, escape is possible. Although the individual likes to feel good-that's dangerous. Although the individual does not like to feel "nervous"-it's safe. Later in life, these people spend a large part of their time feeling "nervous."² What an unfortunate state! When a traumatic incident-even a small one-happens, the individual may be thrown into this "nervous" feeling. Surprisingly, nothing traumatic has to happen to produce the "nervous" feeling. The simple fact that everything is good (too good, for too long) can throw these people into it. As if this first terrible suffocation experience is not bad enough, let us examine the response when oxygen deprivation actually happens again, see chart #3. The fetus cannot discern the difference between the resulting feelings and the ones which occur during recovery. Therefore, the true feelings seem to be just another response which can be controlled. So, upon reaching the escape level of intensity, E, psychological coma is produced and feelings revert to homeostasis as before. However, since this is not a true coma, the brain is still receiving messages of increasing oxygen depletion. When the amplitude of these feelings reaches a degree beyond which the brain can no longer ignore, it becomes impossible to retain the homeostasis feeling. Instantly, the feelings change to extreme panic, depression, hopelessness, and exhaustion, immediately followed by loss of consciousness-dying. This is a terrible shock, and a direct association is now forged between homeostasis, panic, depression, hopelessness, exhaustion, and dying. From this point in time, throughout life, the individual will live within the confines of "nervousness," never allowing himself or herself to feel good. What they will call "feeling good" is the upper edge of nervousness, and what they will feel as intolerable is the lower edge of nervousness. The nervousness I have just described is a state of feeling with an upper and lower limit in strength of emotion. (See chart #4.) FEAR OF FEAR ITSELF is a very important result of oxygen deprivation. So far in all my experience, I have yet to find FEAR OF FEAR resulting from any other cause. The fetus does not know where it is, it does

not know what is happening, and it does not know what to do. In fact, there is nothing it could do if it did know. The only thing the fetal brain can record about this incident is what it feels (physically and emotionally). Because it is not aware of the true cause (oxygen deprivation), these emotions take on aspects of both cause and effect: a preceding emotion, in essence, becomes the cause of the following emotion. The "nervous" individual avoids the feeling of dying by avoiding the intense feelings of panic, depression, hopelessness, and exhaustion. Because they are felt first, JUST PRIOR to "DYING," these feelings seem to be causative to the feeling of dying.



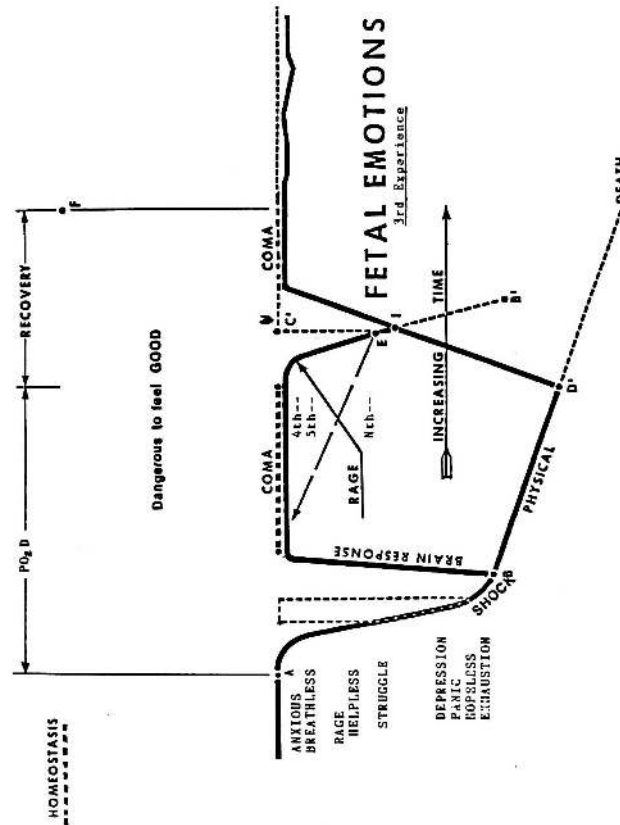
The emotional feelings in recovery relate to the same feelings as those when consciousness was lost except in magnitude. However, they are understood differently by the fetus. The continuum of recovery feelings is considered safe, whereas, that point just before loss of consciousness is considered lethal. The safe feelings are, therefore, capable of becoming the dangerous feelings. The only difference between them is their position on opposite sides of the escape line. The fetus has, in fact, divided the continuum of suffocation feelings in two, calling one part "safe" and the other part "lethal." The need to control and stay in the safe feelings is simply to stay out of the lethal feelings. When fear is in the present, there is never any doubt of the cause because one is receiving sensory input relating to being in a dangerous situation. Your fear in magnitude will be relative to the importance of that situation-not the old "nervous" feeling. Control of old emotions comes about by recognizing and ignoring the old feeling, not by trying to do something about it. When an individual realizes, "I feel 'bad,' but not about this situation," it becomes possible to ignore the feelings. Once justified, however, the old feelings will remain because a reason has been accepted to account for them. Nervous people get a feeling of dread, which is anticipation of the lethal feelings. These feelings do not usually appear in the form of a fear that they will die of suffocation, despite a feeling of breathlessness which may or may not accompany it. They feel fearful that something "bad" will happen. Therefore they would like to avoid whatever it is that may happen, if they can figure out **WHATEVER IS GOING TO HAPPEN**. The situation is that the individual is now feeling dreadful and is

looking to the future to find a reason for it. In the true relationship between CAUSE and EFFECT, cause is always first. In the case of the above-mentioned terrible feeling of dread, the effect is first felt, then the individual tries to find a cause to justify it. This reaction must, therefore, be false. The cart is before the horse. Nothing has happened at the present time to cause this "old" feeling of fear. When fear is real, there is never any doubt of the cause because you are receiving sensory input relating to being in a dangerous situation. Your fear will be, in magnitude, relative to the importance of that situation-not the old "nervous" feeling.



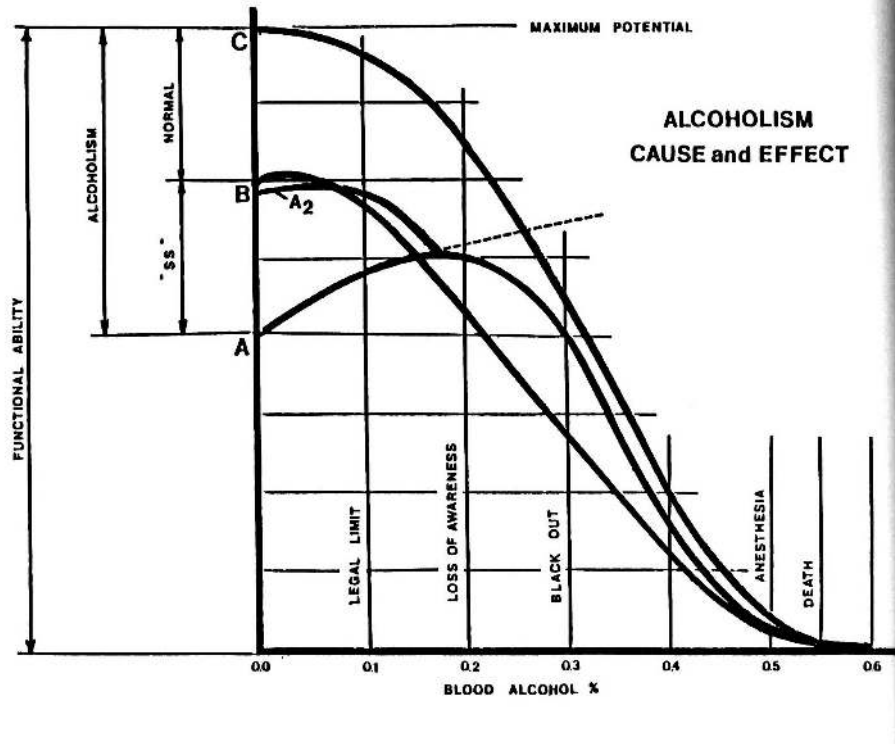
When something happens, we always have a normal, reasonable response to it. However, the brain, without conscious realization, may associate it with an old traumatic incident. The emotional response to that old incident, if it is of greater magnitude, will take precedence over the new response. When the individual justifies this old feeling as being "caused" by the new incident, the old feeling will motivate the reaction to the new incident. The manifested reaction does not fit the circumstances, and does not produce the appropriate results. It may even produce a situation worse than existed before the person reacted. On this basis, we can say any over reaction is an old reaction, and also an old reaction has nothing to do with a current event. Control of old emotions comes about by recognizing and ignoring the old feeling, not by trying to do something about it. When an individual realizes, "I feel "bad," but not about this situation," it becomes possible to ignore the feelings. Once justified, however, the old feelings will remain because a reason has been accepted to account for them. Psychosis in Families As you will recall, a second true experience of oxygen deprivation resulted in the fetus becoming just as afraid to feel good (homeostasis) as it was to feel panic, depression, hopelessness, or exhaustion. The upper limit of the "nervous" feeling (zero-the coma feeling) became the best it could allow itself to feel, safely. Extrapolating this experience to a third (see chart), then on to a fourth, fifth, etc., it seems to me that the upper limit of "nervousness" would then be reduced until the fetus could no longer tell the difference between what it was escaping from and what it was escaping to. In later life, this might account for a complete withdrawal from reality back to childhood when everything was taken care of by the parents and no

responsibility for self was imposed. Therefore, I propound that a child may be born with a predisposition toward psychosis as a result of prenatal oxygen deprivation. The difference between "nervous breakdown," borderline schizophrenia, and schizophrenia becomes the number of prenatal oxygen depriving events which will, in turn, determine the amount of self confidence the individual will be able to muster later in life. I believe this negates the possibility of "heredity" and establishes the condition as the result of "congenital accident."^{12,13,14,18}



Alcohol and Drug Abuse Related to PSS In my experience covering more than two decades, I have yet to find one alcoholic and/or drug abuser who has not exhibited PSS. Alcohol and Drug abuse results from the use of these materials as a learned escape mechanism, in place of the psychological coma which has hitherto been relied upon for escape from PSS. Alcohol and Drugs reduce the individual's ability to feel, therefore, provide relief, or preferably blackout, even before reaching the escape level. Since escape by means of chemicals can occur with less magnitude of emotion (before reaching the escape level) and without mental effort, this learned response becomes the method of choice. The drive for survival thus becomes attached to ingestion of drugs which seemingly maintain control of PSS within acceptable limits or produce a blackout, which equates to "coma" as an even better solution to the problem. The individual "uses" in order to escape the feelings which, within his/her own mind, would immediately be followed by dying. Given the choice of dying now or in the future, but not the near future hopefully, the addict does as I would under the circumstances. He/she chooses the future and so, uses the drug now. It is essential to resolve PSS in order to achieve tranquility. In all current treatment modalities, the individual is helped and induced to abstain from "using." Since the use of drugs provides control and/or escape from PSS, abstinence throws the individual back into strong nervous feelings and he/she needs the old "friend" in order to survive. When these emotions are resolved, the need to escape, which motivates the need to drink, vanishes and it is no longer difficult to abstain. Only the habit of drinking excessively and the physical addiction remain to be dealt with by the usual methodology. It is important that the individual follow up with treatment of these two lesser problems. Refer to chart. ALCOHOLISM-CAUSE and

EFFECT-is a plot of "ability to function" related to "blood alcohol." Other hallucinatory drugs produce a similar effect. Line C represents maximum potential which reduces with any amount of alcohol in the system. We strive to reach our maximum potential, but no one ever achieves it because we all have emotional inhibitions which prevent us from doing so. Subtracting emotional inhibition from line C, we get line B. At about 0.03% blood alcohol, the so-called normal individual feels better-a little more relaxed, a little less inhibited-because alcohol reduces the ability to feel anything. From this point on, it is all down and one is well aware of functional ability becoming worse. The normal person does not like to feel "bad" so he tends to quit drinking. He learns, "If you drink too much you feel lousy, and if you quit drinking you feel better."



With the additional inhibition of PSS, the alcoholic functions on line A, learning, "If you drink a lot you feel better and better, if you quit drinking you feel worse and worse." As this individual approaches the peak of his ability to feel better by drinking, loss of awareness occurs and blackout becomes predominant beyond this point. As a result, the alcoholic never remembers how lousy he/she felt and so expects to feel better and better-the broken line shows this false expectation. If a little is good, more is better. Once over the peak of feeling better, temporary memory says "I'm not feeling so good." Permanent memory says, "I must be slipping back, so I need another drink." This is where the downward spiral to oblivion begins. When PSS is resolved, A is brought up to A(2). Danger lies in trying to drink because comparison of function is made to former feelings, so it seems almost as if alcohol has no effect because he/she still feels better than they ever did before, even with alcohol. Upon drinking enough to intersect the old pattern, they will follow it and upon recovery, they will revert back to A. Therefore it is important to have follow up treatment with A.A.. It is easy to be fooled. Don't take the chance. The chart makes it apparent that one can feel better without alcohol than with it. After years of drinking or drug use, this is not an easy to learn idea! Time and Magnitude of Oxygen Deprivation In his studies of primates, Dr. William Windle has established that a full term monkey can survive 8 minutes of total oxygen deprivation without any brain damage at all; and also that ability to withstand oxygen deprivation is a function of development rather than environment. On this basis, the human fetus should be able to withstand oxygen deprivation better than a monkey fetus at the time of birth. A newborn monkey placed on its back will immediately roll over and get onto its feet, demonstrating greater development than the human neonate. Projecting this information, it would seem that in the human fetus, at least 8 to 10 minutes would be a minimum expectation for brain damage to begin,

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and 16 to 20 minutes more for death, making a total of an estimated 25 to 30 minutes for death to result from total oxygen deprivation. Longer periods of time would certainly be required for lesser degrees of anoxemia.^{5 22} In all mammals, with total oxygen deprivation, the adult experiences brain damage in approximately 3 minutes, and in 9 minutes the adult individual is essentially dead. Stress The seven emotions comprising PSS are the basis of severe emotional stress. These are the feelings responsible, in most cases, whenever a qualified person feels he/she can't handle the job; when the world seems too miserable or painful to go on in it; or when rejection by a loved one is devastating. PSS is the predominant stress which leads to "nervous breakdown" or suicide. I do not infer in any sense that all stress is PSS. I do say, however, when the reaction to stress is very unreasonable, it is almost always because of this internalized (subconscious) manifestation of PSS.

Depression is the factor among the seven in PSS which is the most misunderstood. I feel it is important to convey my understanding of this very significant emotion. In its origin, depression is a physical manifestation. Every cell in the body requires oxygen in order to function. As oxygen deprivation continues, the cells become progressively less able to function. The result is that every function is reduced accordingly-down, down, down-ultimately to the point of death. Later in life, this physical feeling can be re-experienced in the same sensations, and mistakenly called an emotion. In this particular relationship, it is invariably accompanied by one or more of the other seven factors, particularly the one of exhaustion. In this context, there would be three ways in which depression can originate: 1. Oxygen deprivation, 2. Virus illness in which a virus invades each cell reducing its ability to function, 3. Toxicosis (a pathological condition caused by the action of a poison or toxin). Within this concept, it is obviously impossible to become depressed as a result of the usual emotional rationalizations such as: I lost my job; my husband, or wife, is divorcing me; my best friend died; I lost all my money, what will I do? PSS will provide depression for you, if you justify it. Knowing the above, can you justify it? I think not! It then becomes possible to ignore the feeling, and it will fade away. There is no way you will continue to feel depressed unless you justify it. In treating those who suffer the debilitating stress of PSS, it is important to press them into re-experiencing their prenatal trauma. When they relive it as an adult, it becomes possible for them to see and understand the errors of their fetal conclusions. With this new knowledge, they can begin to separate the old feelings from new experiences, and become able to ignore the old ones instead of trying to do something about them. When something is not important, it is easy to ignore. The thought of having nearly died at the time of birth is not a happy thought, but it certainly has nothing to do with us now. It simply is not important now. Prenatal Oxygen Deprivation is the cause of the most terrifying of reactions to stress in all mankind. This syndrome, which I have described, is the most DEBILITATING, the most FRIGHTENING, the most WIDELY GENERALIZED, the most PERSISTENT, and the most MISUNDERSTOOD. I believe the PRENATAL SUFFOCATION SYNDROME presents the most important challenge to psychotherapeutic treatment today. Some physical causes are: 1. Maternal smoking of tobacco. 2. Alcohol and Drug Addiction 3. Problems of umbilical circulation. 4. Placental disease. 5. Premature (partial) separation of placenta. 6. Cardiac disease. 7. Maternal anemia. 8. Pneumonia with inadequate aeration or use of sulfanilamide and/or other drugs which reduce oxygen carrying capacity of maternal blood. 9. Maternal fever, particularly during labor. 10. Hard and prolonged labor. 11. Very tight cord around the neck. 12. Kinked umbilical cord. 13. Prematurity. 14. Nitrous oxide anesthesia given for minor operations. 15. All of the common drugs used to relieve pain during labor have been shown to increase the risk of neonatal apnea. Emotional causes of oxygen deprivation are fear and/or anger in the mother which may induce the "fight or flight" syndrome which causes a reduction of blood supply to the uterus resulting in oxygen deprivation to the fetus. This condition can be harsh enough, depending upon severity of the shock and length of time endured, to cause death to the fetus.^{4,9,15} Sidebar Presented at San Diego, California, 2nd International Congress on Pre- and Peri-natal Psychology, July 26-28, 1985. Footnote Notes 1. Bobson, Pernoll, and Bendo; Diagnosis and Management of Fetus and Neonate at Risk, 4th Edition; "5-10% of newborn infants have some respiratory difficulty after birth . . . Meconium staining of amniotic fluid at birth is observed in 9-16% of all deliveries. The percentage dying of congenital anomalies incompatible with life

has increased as asphyxia and related respiratory distress receive improved care or are prevented.

Nevertheless, Perinatal asphyxia remains the chief factor in death and morbidity. 2. Despert, 1946, reported that anxiety (without external stimulus) or phobia (out of proportion to the external stimulus) was found in patients having a history of difficult birth including impaired breathing at birth. 3. Friedman, Kass, Sachtleben, and St. John: Placental Oxygen Consumption in Vitro: 611 infants with recorded Apgar scores, 113 (18.5%) incidence of neonatal depression-Apgar scores less than 4. 4. Goodwin, Care of the Fetus, p 42; "Among our patients, maternal cardiovascular disease is responsible for approximately 30% of cases of SGA ... As a rule, the degree of fetal retardation is directly proportional to the degree of maternal hypertension." 5. Keith and Norval, (1950) state, "The beginning of respiration after birth can be delayed about 15 minutes, and the human fetus at term is said to tolerate complete anoxia for as much as 30 minutes or an incomplete anoxia for a longer period." 6. Larsen ('31) Histories of 1,000 mental defectives found only 28 instances of asphyxia at birth; but brain injuries at birth, hemorrhage, use of forceps, long labor and prematurity made up 22% of the sample. 7. Little, Streissguth, Barr, and Herman: The Journal of Pediatrics, Vol. 96, No. 6, 1980, pp 974-977, Decreased Birth Weight in Infants of Women Who Abstained During Pregnancy. "That maternal alcohol abuse prior to conception is associated with intrauterine growth retardation, even if abstinence is reportedly maintained during pregnancy, suggests that a history of maternal alcoholism, as well as heavy drinking, may pose a risk to optimal development of the fetus." 8. McNeill and Wiegerink, Behavioral Patterns and Pregnancy and Birth Complication Histories in Psychologically Disturbed Children, (J. of Nervous and Mental Diseases, Vol. 152, No. 5) "Even though Pregnancy and Birth Complications (PBCs) are a feature of the disturbed subjects as a group, PBCs might be hypothesized as having a general stressor or diathesis-establishing role for psychological disturbance." 9. McPhail and Hall, Am. J. Obs. & Gyn, Vol. 42, 1971, p. 696; A Consideration of the Cause and Possible Late Effect of Anoxia in the Newborn Infant, "A high incidence of severe apnea was noted in the babies born of mothers who became excited. Regardless of cause, excitement is one of the first signs of cerebral anoxia. A baby born of a mother showing signs of anoxia would be very likely to be apneic at birth." 10. Pasamanic, et al., 1956, argued that toxemia and hypertension in pregnancy are more prone to produce fetal anoxia than the mechanical difficulties of delivery. 11. Dr. Reinold, [from Verny, op cit.] in a beautiful, simply designed experiment, asked pregnant women to lie prone for twenty to thirty minutes on a table under an ultrasound machine. He deliberately did not tell them that when a woman lies like this, her child eventually quiets down and lies still too. As each child relaxed, his mother was only told that the ultrasound screen showed her baby wasn't moving. The terror that information produced was expected and deliberate. Dr. Reinold wanted to see how quickly a mother's fear registered on her child and how he reacted when it did. In every case, the response was swift: seconds after each woman learned her child was lying motionless, the image on the ultrasound screen began stirring. None of the babies were in any imminent danger, but as soon as they sensed their mothers' distress, they began kicking mightily." (Dr. Hull believes, however, that this action is evidence of oxygen deprivation as a result of the mother's distress.) Verny, Thomas, M.D.; The Secret Life of the Unborn Child, p. 134. "A recent report from the University of North Carolina shows they (fearful women) also run a materially higher risk of incurring birth complications. Women in this study who had the longest labors, the most forceps-attended deliveries, and bore babies with the lowest Apgar scores also scored highest in testing on dependency, fears for self and fears for baby." 12. Rutt and Offord, Prenatal and Perinatal Complications in Childhood Schizophrenics and their Siblings, "Childhood Schizophrenics had a higher rate of prenatal complications than their siblings." 13. Sameroff and Chandler reviewed a number of studies that described the effects of chronic emotional disturbance, and more particularly, anxiety, in increasing the probability of pregnancy and delivery complications." 14. Sameroff and Zax, Perinatal Characteristics of the Offspring of Schizophrenic Women, (J. Nervous and Mental Diseases, Vol. 157, 1973, p. 191-199) "Chronicity of mental disorder was more strongly related to number of delivery complications than any particular psychiatric diagnosis ... indicating a greater number of birth difficulties among Schizophrenic mothers than nonschizophrenic

mothers. In addition, however, the neurotic depressives in our study show similar numbers of birth difficulties as the schizophrenic group. 15. Schreiber noted that 70% of a large group of children having brain defects were found to have been asphyxiated at birth. *Amer. Journal of Obs. & Gyn.*, 1971. 16. Schreiber ('39) In 252 children with mental deficiency, 176 (70%) had histories of anoxia at birth. ('38) In 500 children with symptoms of cerebral injury, 70% had history of apnea at birth. 17. Verny, op. cit.; p. 25, "The researchers began with the assumption that fetal activity is frequently an accurate sign of anxiety. If a child's behavior in the womb has any predictive meaning at all, they reasoned, the most active fetuses would one day grow into the most anxious youngsters. That is exactly what happened. The babies who moved around the most in utero grew into the most anxious children. They were not simply a bit more fretful than normal. They were bursting, bubbling over with anxiety. These two and three year olds felt an almost heartbreaking discomfort in even the most common social situations. They shied away from their teachers, from their schoolmates, from making friends, and from all human contact. They were most comfortable, most relaxed and least anxious when they were alone.) (and on p. 85, "Maternal emotions such as anger, anxiety and fear will also prompt furious kicking.") 18. Verny, op. cit. footnote p. 27, "There will always be people who will look for physical causes of emotional disturbances. However, after thousands of studies of schizophrenics and manic-depressives, no one chemical has been found in their blood systems the transfer of which would reproduce their symptoms." 19. Verny, op. cit.; *The secret Life of the Unborn Child*, p. 70, "The results from the subjective section were more enlightening. Peacefulness was the most commonly reported womb feeling (43%), but it was followed very closely by anxiety (41%). There was a high incidence of traumatic birth memories: Over 60% of the subjects said they had remembered feeling suffocated during birth . . ." 20. Verny, Thomas, M.D.; *The secret Life of the Unborn Child*, p. 71, "Like many other reports, mine also uncovered a strong correlation between maternal smoking and neurotic behavior, which isn't surprising, since, as we saw in the first chapter, smoking may predispose an unborn child to severe anxiety. The same negative correlation turns up with drinking, and though the physical effect of alcohol on the fetus is far more devastating than that of cigarettes, I believe, again, that what is being measured here is a psychological variable. The woman drinks more because she is disturbed and it is her negative feelings that really harm her child." 21. Verny, op. cit. p. 213, "Some behavioral problems are predictable prenatally and may appear immediately upon birth, as is the case with babies whose mothers are alcoholics or drug addicts. Similarly, babies whose mothers have undergone severe stress, as I described in some of the previous chapters, should receive special attention in the early postnatal period. Any baby that withdraws from being held, that constantly cries, that fails to gain weight may be communicating through these very ways his emotional distress. Hyperactivity often begins in the womb, and the mother of such a child may report that he was a "whirling dervish" before birth, never giving her a moment's rest." 22. Windle, *Neurological and Psychological Deficits of Asphyxia Neonatorum*, 1958: "The same mechanism responsible for the production of the severe neuromuscular deficits can also be associated with more remote or delayed abnormalities that come to the fore only when the afflicted individual is in a stress situation. Thus a child may seem perfectly normal until his activities come up against competition or when he starts school and must adjust to new standards of behavior. Then the damaged brain can no longer cope with the situation, the child comes to the attention of teachers and the community as a behavior disorder. 23. Zax, Sameroff, and Babigian, *Birth Outcomes in the Offspring of Mentally Disordered Women* (*Am. J. Orthopsychiatry*, April 1977) "Children of neurotic, depressive women had lower Apgar scores and more fetal deaths." *Follow-Up Study From Birth of the Effects of Prenatal Stresses*, Vol. 15, 1973, p. 773; "The association between personal tensions during the pregnancy, and hyperactivity in the child appears to be a very close one ... As an explanation of the close relationship found between prenatal interpersonal tensions and child morbidity, the postnatal interreaction of mother and child has little experimental support... Parallel study of perinatal death suggested that severe emotional stress during the pregnancy is more damaging to the child than physical illness." Author Affiliation William F. Hull, Ph.D.

Publication title: Pre- and Peri-natal Psychology Journal

Volume: 1

Issue: 2

Pages: 111-134

Number of pages: 24

Publication year: 1986

Publication date: Winter 1986

Year: 1986

Publisher: Association for Pre&Perinatal Psychology and Health

Place of publication: New York

Country of publication: United States

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

ISSN: 08833095

Source type: Scholarly Journals

Language of publication: English

Document type: General Information

ProQuest document ID: 198673978

Document URL: <http://search.proquest.com/docview/198673978?accountid=36557>

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Last updated: 2010-06-06

Database: ProQuest Public Health

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