The Vulnerable Prenate

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Full Text: The prenate (i.e., the unborn baby) is vulnerable in a number of ways that are generally unrecognized and unarticulated. Most people think or assume that prenates are unaware, and seldom attribute to them the status of being human. I recall a recent train trip, where an expectant mother sat in a smoking car filled with boisterous and noisy people. I asked her whether she had any concern for her unborn baby, and whether she thought the smoke or the noise would be bothersome to her unborn child. Her reply was, "Well of course not, my dear. They are not very intelligent or awake yet." Nothing could be further from the truth. Theory and research from the last 20 years indicates that prenatal experiences can be remembered, and have lifelong impact. The major purpose of this article is to clarify the conditions under which prenatal experiences may be lifelong and to describe the theoretical and research perspectives that are necessary to understand the effects of prenatal traumatization. In addition, because the incidences of personal and societal violence are at an all-time peak and headed higher, this paper discusses the effects of pre- and perinatal trauma on aggression and violence. INTERACTIONAL TRAUMA The effects of prenatal traumatization cannot be predicted without knowledge of other factors, and prenatal experiences are likely to have lifelong impact when they are followed by reinforcing conditions or interactional trauma. The term interactional trauma means that traumas interact with each other in producing their effects. In statistical analyses, interactional means that the effects of factors depend on the presence of other factors. Both of these definitions communicate the meaning of interaction as it is used in this article. For example, it is unlikely that being stuck during the birthing process causes claustrophobia during adulthood. However, claustrophobia is more likely if similar, reinforcing traumas occur. In one such case that I treated, a baby who had been stuck during his birth was also locked in a closet for 24 hours as a child, and held and choked by his brother on several occasions. Several points are relevant here. First of all, prenatal traumas provide "tinctures" for later experiences. Stated differently, life experiences are perceived in terms of prior and unresolved traumas. When a baby is stuck during birth, the baby is likely to perceive later events as entrapping, or to unconsciously manipulate or choose life situations that bring about entrapment. This process is called recapitulation. secondly, similar or recapitulated events, independent of perceptual processes, are likely to reinforce prenatal traumas, resulting in relatively chronic symptoms. In the case of the baby just described, childhood events acted as reinforcements for the birth trauma, resulting in chronic claustrophobia. THE EFFECTS OF PRENATAL EXPERIENCES: THEORETICAL PERSPECTIVES- PRENATES ARE CONSCIOUS, AWARE BEINGS During the 1995 APPPAH Congress in San Francisco, David Chamberlain shared a case that exemplifies the consciousness of prenates. In this case, a baby was undergoing amniocentesis. Videotapes of the amniocentesis showed that when the needle was inserted into the uterus, the baby turned toward the needle and batted it away. Thinking that they had seen an aberration, medical staff repeated the needle insertion, and again, the baby batted the needle away. In addition, there are numerous anecdotal reports that babies routinely withdraw from needles as they are inserted into the uterus. From these observations, it is safe to conclude that babies are very conscious of what is happening around them, particularly with respect to events that have impact on them personally. In her book From Fetus to Child, Piontelli cites cases of prenatal awareness. She describes a twin pair, at about four months of gestation, who were very conscious of each other, and were also involved in dominance-submission interactions. One of the twins was dominant and aggressive, the other submissive. Whenever the dominant twin was pushing or hitting, the submissive twin withdrew and placed his head on the placenta, appearing to rest there. In life, when these

twins were four years of age, they had the same relationship. Whenever there was fighting or tension between the pair, the passive twin would go to his room and put his head on his pillow. He also carried a pillow and used it as his "security blanket," resting on it whenever his twin became aggressive. From this and other research (such as David Chamberlain's Babies Remember Birth, and Elizabeth Noble's Primal Connections), it seems clear that prenates are conscious beings and that behaviors that begin in utero are also likely to carry over into later life. PRENATAL EVENTS ARE REMEMBERED For years it was hard to understand how prenatal experiences could be remembered. The central nervous system is very rudimentary during the prenatal period, and is not yet myelinated (covered by a protective sheath). When there is no myelination, the nervous system cannot function efficiently enough to support memory. However, anecdotal reports of adults regressed to the prenatal period and remembering prenatal events proliferated in primal and regressive communities. In 1970 Dr. Graham Farrant, an Australian medical doctor, began experiencing prenatal events and recording his body experiences. He was quite astonished to discover that he experienced most of his significant prenatal memories at a cellular rather than a tissue or skeletal-muscular level, and he referred to his recollections as cellular memory. In 1975 Dr. Frank Lake, an English theologian and psychiatrist, found that prenatal memories stemmed from viral cells, that viruses were primitive prenatal cells that formed during trauma and carried traumatic memories. He consistently referred to prenatal memories in terms of cellular memories. Over the last five years, there has been a considerable amount of research done in cellular biology, all of it supporting the theory that memories can be encoded in cells. The research of Dr. Bruce Lipton, reported in the 1995 APPPAH Congress, is relevant here and supports the conclusions of Farrant and Lake. PRENATAL MEMORIES MAY BE THE MOST INFLUENTIAL A group of European psychologists, led by R. D. Laing and Frank Lake (both now deceased), contend that prenatal memories are the most influential because they are the first. This perspective is apparent in Laing's book entitled The Facts of Life, where he says, "The environment is registered from the very beginning of my life; by the first one (cell) of me. What happens to the first one or two of me may reverberate throughout all subsequent generations of our first cellular parents. That first one of us carries all my 'genetic' memories" (p. 30). He goes on to say, "It seems to me credible, at least, that all our experience in our life cycle from cell one is absorbed and stored from the beginning, perhaps especially in the beginning. How that may happen I do not know. How can one cell generate the billions of cells I now am? We are impossible, but for the fact that we are. When I look at the embryological stages in my life cycle I experience what feel to me like sympathetic vibrations in me now . . . how I now feel I felt then" (p 36). Frank Lake mirrored Laing's perspectives. Lake contended that the most formative experiences were ones that occurred prenatally, especially during the first trimester. In the U.S., Lloyd deMause has also written about the social, cultural, and political influences of prenatal experiences, and reported on these findings during the 1995 APPPAH Congress. PRENATES INCORPORATE PARENTAL EXPERIENCES AND FEELINGS From his regressions with adult patients, Lake also found that the most influential events were maternal experiences that passed biochemically through the umbilical cord by means of a group of chemicals called the catecholamines, but it is also true that prenates incorporate psychic prenatal feelings and experiences, especially those of their mothers. Maternal emotions (and paternal emotions through the mother's emotional response to them) infiltrate the fetus. Research shows that what mothers experience, babies also experience. A good example is the following case. A woman's father died just prior to the conception of her child. She spent the whole nine months feeling depressed and grieving the loss of her father. If it is true that babies experience and remember what their mothers experience, then her baby should also have experienced loss and depression, and these feelings would be expected to resurface during childhood and/or adulthood. This appeared to be the case. As a child, her baby was periodically depressed, and medical personnel could find no physiological or psychological basis for the depression (They were not cognizant of the child's prenatal experiences). When the child was depressed, he would draw pictures of old and dying men in caves (in pre- and perinatal psychology, caves are symbolic of wombs, the place where he experienced the loss of his grandfather). After drawing, he would feel

better for a while, but the depression would slowly return. He was unconscious of any connection between his drawings and his grandfather's death. The depression became chronic when his parents were experiencing tension (his mother and father were living separately but raising him together). The tension symbolized the loss of his father and grandfather. His drawings sometimes depicted a little girl frantically searching for dying men. The little girl probably represented his own feminine, the mother's inner child, and/or a female twin's experience of the grandfather's loss. It is unlikely that grief would have resurfaced as chronic depression without the reinforcing conditions of father loss and parental discord. It is important to realize that although prenates do take on the prenatal experiences of their parents, they also have their own unique experiences during the prenatal period, independent of their parents. The mechanisms of how this works are not clear, but numerous anecdotal reports and clinical cases show that prenates have their own experiences. For example, I recall the reports of a regressed child, a twin, who was repeatedly subjected to verbal and physical fights between his mother and her boyfriend during the prenatal period. His experiences of the prenatal fighting were not what might be expected, based on this paper's content. He reported that his mother and her boyfriend were constantly fighting, but he and his twin would respond to this by cuddling up and rocking while the fighting went on. During the fighting, they both felt quite clever (to have avoided the tension) and relaxed. Perhaps the presence of a comforting twin can make separation from parental experiences feasible or possible. WHEN REINFORCED, PRENATAL EXPERIENCES MAY HAVE DRAMATIC AND SYMPTOMATIC INFLUENCES In the case of the woman who lost her father just prior to pregnancy, the baby presumably experienced the same loss that his mother experienced. In addition, a very tangible and personal trauma happened shortly thereafter. Early in the pregnancy, when she was eight weeks pregnant, the mother's husband abruptly left her for another woman. She was shocked by the experience and felt deeply abandoned. Presumably her unborn child felt abandoned as well. Because the woman had little financial security and did not want to raise a child by herself, she decided to abort her child. She attempted several abortions, most often by using the hooked or curved end of a coat hanger. As a child, her baby was periodically sadistic and selfdestructive. The manifestations of his sadism bore striking resemblances to his mother's abortion attempts, although he was unaware of them. He burned himself with cigarettes and gouged private parts of his body with sharp metal objects. His favorite sadistic instrument was a fishing hook, but he complained he could never buy ones that were big enough. As a young adult he was arrested thirty times for assault, and his modus operandi was reminiscent of his mother's attempts to abort him. He usually assaulted his victims when they were sleeping, by using heavy braided wire with a wire hook welded on the end. AGGRESSION AND VIOLENCE ARE PATHOLOGICAL SYMPTOMS RESULTING FROM MULTIPLE, REINFORCING TRAUMAS WITH THEMES OF LOSS, ABANDONMENT, AND AGGRESSION In the case just described, the prenate experienced the intense loss and abandonment that his mother experienced. In addition, he also experienced the abandonment that comes with parental narcissism, (i.e., his mother was so absorbed in her abandonment and loss that she had little or no cognizance of him, nor did she have time or energy to celebrate his presence). On the contrary, he was perceived as a burden, and as something to get rid of. Consequently, he also experienced the aggression of his mother's abortion attempts on his life. PRENATAL AND BIRTH TRAUMAS ARE MIRROR IMAGES Prenatal traumas have two distinct impacts on birth. First of all, birth is often perceived and experienced in terms of prenatal traumatization. So, for example, babies who experience abortion attempts are also likely to experience birth as annihilative. Babies who experience near-death during implantation in the womb are likely to experience birth as a near-death experience. Babies who experience aggression or violence while in the womb are likely to experience the interventions of birth as aggressive and violent, even though there may be no such intent on the part of medical personnel or parents. Secondly, as Sheila Kitzinger has documented, whenever there is significant prenatal stress (trauma), there is an increasing statistical likelihood that birth complications will occur with greater frequency. The greater the degree of stress or trauma during the prenatal period, the greater the likelihood of birth complications and obstetrical interventions. This is exactly what occurred in case of the mother whose

father died just before she became pregnant, and who attempted several abortions. The mother had a very difficult birth with long labor and many complications. Many interventions were used and repeated, among which were inductions, augmentations, sedations, analgesias, anesthesias, forceps, episiotomy, intensive care placement, and respiration. It should be pointed out that the severity of symptomology in the present case is due to the fact that there were additional and reinforcing traumas as well, all involving loss, abandonment, and aggression. When the baby was three months old, the mother took him shopping in a stroller, forgot that he was with her, left him in an aisle of the store, and only realized her error hours later. In addition to this, she had a boyfriend who was repeatedly and physically abusive with her son during his early childhood. These multiple and reinforcing traumas manifested in his childhood and adulthood as aggression and violence. PRENATAL AND BIRTH TRAUMAS IMPAIR BONDING AT BIRTH In addition to posing a risk of birth traumatization, prenatal traumas have another and more insidious impact. When traumas occur prior to or during birth, the quantity and quality of bonding is radically reduced. This reduction occurs for two reasons. The first has to do with the defensive dulling of mind and body. When traumas and shocks occur, there is a natural physiological dulling of the mind and body in order to defend against traumatization and shock (Bloch, 1985). This self-anesthetization occurs because of the hormonal changes that normally occur in the body during and after trauma and shock. When the body and mind are dulled, and when the body is exhausted from stress, the quantity and quality of bonding are lessened. The second impact has to do with the failure of parents and others to acknowledge traumatization, which diminishes the bonding process even further. When traumas occur, there is a critical period of time afterward during which humans require understanding, acknowledgment, and compassion in order for shock to subside and healing to begin. However, it is rare for babies to receive understanding, acknowledgment, and compassion after their prenatal and birth traumas, simply because no one knows or believes that traumas have taken place. As has been verified in my own clinical research with babies, unacknowledged traumas create distrust in babies, and this significantly impedes the bonding process. In contrast, it is informative to witness the level and depth of bonding in babies who have not been traumatized, or whose traumatization is being seen and acknowledged. The bonding is noteworthy by its depth, intensity, and duration. One only has to witness such bonding to realize that bonding is significantly reduced and altered by the presence of unacknowledged and unresolved traumatization. LACK OF BONDING PREDISPOSES THE INDIVIDUAL TO AGGRESSION AND VIOLENCE In my work with infants over the past 25 years, I have discovered some important interrelationships between prenatal trauma, birth trauma, bonding, and aggression. The first interrelationship is that birth actively impairs the bonding process because many aspects of the birthing process are psychologically and physically painful for babies. Medical exams and medical tests are often experienced by babies as unnecessary, invasive, and painful, and this is rarely acknowledged. Medical personnel routinely separate babies from parents after birth, and separation is often experienced as terrifying abandonment. Placement in intensive care is frequently experienced as terrifying, lonely, overstimulating, and painful abandonment. Anesthetization is particularly impactful on bonding because residual amounts of anesthesia are common in babies, even hours and days after birth, and anesthesia makes babies (and mothers) numb and therefore less available to the bonding process. Epidurals were thought to be superior to other anesthesias because they would not inhibit the bonding process as much, but research shows that mothers who receive epidurals show less attachment to their babies than mothers who do not. These are some examples of the effects of birth trauma on bonding. In all cases bonding is affected because it is difficult for babies to trust their parents when their parents do not accurately perceive or acknowledge their prenatal and birth traumas. In general, the greater the number and severity of unacknowledged prenatal and birth traumas, the greater the impact on bonding. A second important interrelationship has to do with the effects of unresolved trauma on bonding. When traumas are largely untreated, the influence on bonding is exacerbated because the traumatized infant remains in a defensive stance with respect to the world, and does not "let the world touch him." Many parents report to me that their babies are very independent, but this is often a cover for

defensiveness. Such babies act as if they are OK, and do not need comforting or support. They do not easily let themselves be comforted and held, either pushing their parents away and/or ignoring their attempts to comfort and console. Many times they will only let their parents comfort them after considerable resistance. Third, it is important to realize that a lack of bonding may be sufficient, in and of itself, to create aggression and violence. This surprising fact has been brought to light by various researchers. For example, Magid and McKelvey (1988) reported that children with severe bonding difficulties do not develop a conscience, and perform a social or antisocial acts without remorse. Felicity De Zulueta summarized research in the field of bonding and attachment, and concluded that violent aggression is the result of damaged bonding. She says (1993, p. 78), "One of the most important outcomes of ... studies on attachment behavior is the emerging link between psychological trauma, such as loss (of a bond) . . . and destructive or violent behavior." She coneludes that the more damage that is done to bonding, the greater the likelihood of aggression and violence during childhood and adulthood. Fourth and finally, it is clear from the observations of clinical researchers that the probability of societal aggression and violence are increased greatly by the presence of aggression or violence during the pre- and perinatal periods of development. Prenates pick up on aggressive and violent energies, and are likely to repeat what they experience in their prenatal life space. WHAT KINDS OF PRE- AND PERINATAL EXPERIENCES UNDERLINE AGGRESSION AND VIOLENCE? As a way of determining the prenatal, etiological bases for violence and aggression, I posed a basic question to a number of experts in the field, among whom were R. D. Laing, Frank Lake, Barbara Valassis, Barbara Findeisen, Stan Grof, Michael Irving, and others. I asked them to report on the kinds of regressive experiences that their aggressive and violent patients had uncovered and/or reported, and that were central in the success of treatment. Among their varied responses were common threads of consensus, among which were: (a) pre- and perinatal experiences were paramount in aggression and violence; (b) childhood experiences seemed to reflect and reinforce prenatal traumatization; (c) aggression and violence were related to the severest levels of pre- and perinatal trauma; (d) certain themes were consistently related to aggression and violence-themes of loss, abandonment, rejection, and aggression; and (e) certain pre- and perinatal traumas were consistently related to aggression and violence. These experiences are described below. In reading through these experiences, it is important to remember several basic principles, references above. First of all, multiple prenatal traumas are more likely to result in violence and aggression than single traumas. secondly, bonding deficiencies are directly related to aggression and violence. The greater the degree of bonding deficits, the greater the likelihood of violence and aggression. Third, prenatal traumas that involve loss, abandonment, or rejection are more likely to impact bonding than other traumatic themes, and are also more likely to result in the complete absence of bonding than traumas involving other themes. Finally, the direct exposure to aggression and violence during the prenatal period is highly predictive of violence and aggression during adulthood. The old adage, "Children learn what they live," is relevant here. Like children, prenates "learn what they live," and prenates subjected to aggression and violence are likely to manifest the same in their adult lives. CONCEPTION When clients who have problems with aggression and violence are regressed, they frequently encounter the experience of conception. They report that they are conscious of traumatic issues outside of themselves, in their family or immediate surroundings. The most frequently mentioned traumas involved forced sex, manipulated sex, date rape, rape, substance abuse, physical abuse, dismal familial, social, or cultural conditions, and personal or cultural shame, such as when children are conceived out of wedlock. They often experience biological encounters as sperm and/or eggs which involve intense aggression, annihilation, death, power, and/or rejection. To cite an example of traumatic conception, one child was conceived out of wedlock in a small religious community where such things were disdained. Her mother experienced shame, guilt, and public ridicule before deciding to "keep her," and the child experienced the same guilt, shame, and ridicule that her mother did. The public ridicule was experienced as particularly annihilating and hostile. This led to characterological patterns of self-righteousness, self-ridicule, masochism, and hostility. IMPLANTATION Implantation is the biological process whereby the

conceptus attaches itself to the uterine wall, and is a vital stage of embryological development where survival is precarious. Prior to and during implantation, regressees report that they experienced the terror of neardeath. They report feeling unwanted and that they have no place to go, no place to belong, and "decide" that the world is a hostile and unsafe place. They often collapse in hopelessness, retaliate in rage, fluctuate between these two extremes, and/or manifest intense rescue complexes (the need to rescue others and/or be rescued). Christ's life was, in many ways, a metaphor of implantation. There was "no room in the Inn," and He had no place that He belonged. And as the Bible declares, His life was manifested in order for Him to save and rescue mankind. Many individuals with problems of aggression report the loss of a twin. Their problems with aggression typically have to do with masochism and/or neurotic self criticism. Embryological research indicates that loss of a twin may be much more likely than originally thought. Embryologists estimate that between 30% to 80% of conceptions are multiple (i.e. twins) rather than single. Since the rate of birthed twins is far less than 30% to 80% percent, embryologists conclude that many conceptions involved the death of one or more twins, usually prior to or during implantation, although some happen after implantation. People who experience the loss of a twin manifest several common dynamics. First of all, there is an ineffable but profound sense of loss, despair, and rage that is connected with twin death. These feelings are usually held in, but are sometimes acted out against others. Secondly, there is a chronic but ineffable and unarticulated fear that loss will happen again, and pervasive insecurity. The threat of loss is defended against by distancing from others, or by engaging in codependent relationships. Third, the ability to bond with others is deficient or neurotic because there is a lack of trust in relationships, or disbelief that relationships will last. Fourth, there is often an over compliance in life, based on the unconscious feeling that "if I don't do what is expected or wanted, I will die." Over compliance feeds hostility and aggression toward others, since one cannot take care of oneself when constantly complying with others. Finally, prenatal experiences of near-death and/or loss are sometimes turned against oneself or others, resulting in sadistic and masochistic behaviors, criminal violence, or sadomasochistic thinking and behavior. DISCOVERY OF UNWANTED PREGNANCY When aggressive clients regress to the prenatal period, they frequently and spontaneously regress to the time of their discovery (i.e., the time the pregnancy was discovered), and many of them are surprised to find that they were unwanted. The discovery of being unwanted typically leads to the realization that lifelong episodes of depression, self-destructiveness, or aggression are a direct expression of prenatal rejection. They typically report that they can trust only themselves, and that their whole lives have been geared toward denying or finding the acceptance and love that they did not receive as prenates. The percentage of aggressive clients who were unwanted at the time of discovery is quite high, and has important implications for bonding disorders. Typical responses to being unwanted are to collapse into helplessness and hopelessness, to rage at others and the world's injustice, and/or refuse to engage in life. PRENATAL AGGRESSION The majority of adults with problems in aggression learn that they were unwanted at the time of discovery, but many of them also learn that they were exposed to other forms of aggression during the preand perinatal period. Some common forms of aggression are warfare, gang fights, domestic violence, conception through rape, physical or sexual abuse of parents or siblings, annihilative energies, intrauterine toxicities, and/or abortion attempts. Prenates who experience one or more of these aggressive conditions are at risk for manifesting aggression and violence, and the greater the number of conditions, the greater the likelihood of aggression and violence. ADOPTION Adoption trauma refers to a broad range of painful experiences that are common to adoption. When children are adopted, they are likely to have experienced some level of abortion trauma-there may have been direct attempts on life, abortion plans with no attempts, or abortion ideations but no plans. All of these are traumatizing to varying degrees. In addition they are likely to have experienced discovery trauma (child unwanted at the time of discovery), conception trauma (child unwanted at time of conception), or psychological toxicity (child exposed to mother's annihilative or ambivalent feelings, or to social/cultural shame). Adoption trauma has many different levels. The lowest level occurs when parents want their children but reluctantly give them up for adoption because external

circumstances dictate. A higher level occurs when parents do not want their children and seriously consider abortion. The highest level occurs when parents are unequivocally opposed to having children, when pregnancies are resented, when abortions, are attempted, when children are put up for adoption, and when children are fostered a number of times. At high risk for aggression are children who experience the severest levels of adoption trauma. PRE- AND PERINATAL MEDICAL PROCEDURES When prenates experience severe forms of traumatization, as described above, they are also likely to perceive subsequent events in similar contexts. This is especially true when subsequent events are stressful life transitions (such as birth, adolescence, first jobs, new relationships, etc.), and/or when subsequent events are symbolically similar to traumatizing events. For example, if prenates experience prenatal violence, then they are likely to experience life transitions (such as birth) in violent ways. Freud called this process recapitulation. Among other definitions, recapitulation means that prenatal experiences shape how subsequent life experiences are perceived. The following case is a good example, because the mother had limited prenatal traumas, which nevertheless influenced her baby's perceptions and experiences of the birthing process. The mother was 28 years old, and had never attempted to conceive a child. Her own mother had had difficulty conceiving children, so she was anxious about her ability to conceive. She wanted to have a child, and in spite of being unmarried, conceived a child with her boyfriend, who was ambivalent. They conceived after much effort, whereupon the boyfriend turned brutal and violent against the mother and her baby (it was later determined that the boyfriend's father had been abusive during the boyfriend's prenatal period). A series of beatings occurred, after which the mother fled. She spent the remainder of her pregnancy in a distant and safe place, under conditions that were close to "ideal." She was attentive to herself, her body, and to her baby. She meditated daily and earned income from work she did at home. She had an extensive and supportive family system as well as friends, and the remainder of the pregnancy was uneventful in terms of other stresses and traumas. She devoted time to her unborn baby every day, talking and singing to him, and doing bonding exercises. She gave birth at home, and described the birth as short and simple, with no complications. In spite of having a largely positive pregnancy and an easy birth, the early abusive experiences haunted her and her baby. In particular, her baby experienced the birth as very traumatic. (This is not an unusual event, even when mothers describe births as simple and uneventful). This was evident in childhood memories of his third trimester and birth. He experienced his mother's jogging during the third trimester as abusive, saying that his head bounced painfully on his mother's pelvic bones. He experienced the perineal massages (given repeatedly during birth) as intrusive, and the contractions as abusive and violent. He was aware of his mother's physical pain, felt the birth was hurting her, and felt guilty that he could not protect her. In short, all of his birth feelings appeared to be overlays and manifestations of his unresolved abuse traumas from the first trimester. It is important to realize that, even more so than children or adults, prenates perceive and interpret life experiences in terms of past experiences. This is so because prenates do not have sufficient neurological integrity or adequate life experiences to assist in discriminating between current and historical realities. When prenates experience abandonment, rejection, violence, or abuse, as has been described in this paper, they routinely bring these experiences to bear during the birthing process. Amniocentesis needles and chorionic villae catheters are commonly perceived as aggressive, annihilating, and/or rejecting instruments. Anesthetic procedures are often perceived as attempts to disempower or to poison (a reflection of abortion trauma). Augmentations (inductions and "breaking waters") are usually experienced as boundary violations. Forceps and vacuum extractions are often perceived as attempts to control or annihilate. Contractions are often perceived as attempts to annihilate, destroy, or impede. For example, one adult who had been exposed to chemical and mechanical abortion attempts (his mother had taken low-dose cyanide pills and repeatedly pummeled her abdomen and uterus) experienced contractions as attempts to beat him to death, and experienced anesthesia administrations as attempts to poison him. It is vital that medical and obstetrical personnel understand the importance and relevance of pre- and perinatal traumas, and understand that birthing babies are likely to experience the birthing process in terms of prior traumatizations. This means that birth can

be very traumatic, simply on the basis of personal history. If this fact were known, then medical interventions could be limited to situations where they were absolutely necessary, or medical interventions could be humanized in a variety of ways. Some useful procedures might be asking the permission of babies to implement procedures and getting responses through the mother's intuition, letting babies know that they might experience pains and discomforts, and empathizing in terms of prior traumas. Letting babies know that birth is a difficult transition with the potential for negative and overwhelming feelings and acknowledging babies postbirth emotions as legitimate expressions of a difficult birthing process could help to minimize potential trauma. It is also important to acknowledge the positive aspects of birthing, the wonder and joy that belongs to the birthing process. Few births are entirely difficult, and few are free from trauma or pain. We need to acknowledge the whole gamut of human experiences as they unfold during the birthing process. TREATMENT It is important that pre- and perinatal traumas be treated as early as possible. This is so because, as previously discussed, early traumas shape how subsequent events will be perceived and experienced. If treatment occurs early on, during gestation or the first year, then childhood experiences can be freed from prenatal influences, and children can live their lives unencumbered by the bonds of trauma. The effects of trauma have been described elsewhere (Emerson, 1992, 1994). However, suffice it to say that unresolved traumas affect the spiritual and psychological development of children. In contrast, children who had no trauma, or whose traumas have been resolved, are clearly unique in the following ways. They are more spiritually evolved, manifest higher levels of human potential, and are developmentally precocious. They exhibit higher self-esteem and intelligence test scores, and they are more empathie, emotionally mature, cooperative, creative, affectionate, loving, focused, and self-aware than untreated and traumatized children (Emerson, 1993). The fact that pre- and perinatal traumas shape how subsequent life events are experienced does not mean that childhood experiences, in and of themselves, are unimportant in terms of human development. On the contrary, childhood experiences are very important in determining and shaping who children will become. It is precisely because childhood experiences are so important that it is vital to free childhood from the bonds of pre- and perinatal trauma. If these traumas can be resolved before childhood, then childhood has the opportunity to be experienced on its own, without traumatic influence from the prenatal period, and without the defensive forces that inhibit feelings of safety, security, and growth. Furthermore, children can be freed to exhibit and manifest their own unique human potential, to utilize their own inherent levels of intelligence, and to become themselves, unencumbered by prior traumas. In addition to these benefits, society can be freed from the increasing burden of aggression and violence. According to statistics reported at the 1995 APPPAH Congress, violence and aggression are on the rise, and are reaching epidemic proportions. Therapists who specialize in anger resolution report that about one client in five carries a significant degree of anger and rage. Aggression and violence are on the rise, and are extremely costly in terms of human lives, in terms of financial and budgetary considerations (prisons, jails, and law enforcement are very costly, and deprive our school systems of needed finances), and in terms of the safe and efficient functioning of our institutions. These violent feelings are directed toward self and others, and are very difficult to resolve for the following reasons. First of all, most therapists do not realize that anger and rage, at their deepest levels, are caused by pre- and perinatal traumas, and are related to perinatal bonding deficits. secondly, most clinicians fail to realize that anger and rage cannot be resolved solely by talking therapies. Instead, anger and rage require physical and emotional release. Third, anger and rage are inextricably intertwined with low self-esteem, shame, guilt, disempowerment, and forgiveness. These concepts need to be understood and recognized in the treatment of aggressive disorders. Finally, the ultimate resolution of rage and anger requires that relevant pre- and perinatal traumas be uncovered, encountered, catharted, repatterned, and integrated into consciousness. Additional aspects of treatment should include opportunities for rebonding, i.e., for bonding in ways that were impossible at the time of traumatization, or bonding in ways that were inhibited by unresolved traumas. The Association for Pre- and Perinatal Psychology and Health, the International Primal Association, Pocket Ranch Institute (California), and Emerson Training Seminars (California) have personnel

and lists of professionals who do such work. References REFERENCES Bloch, G. (1985). Body &Self: Elements of Human Biology, Behavior, and Health. Los Altos, CA: William Kaufmann, Inc. De Zulueta, F. (1993). FTOTO Pain to Violence. London: Whurr Publishers. Emerson, W. (1994). Trauma Impacts: Audio taped presentations. Seattle 1992, Petaluma 1992, and March 1993. Emerson Training Seminars. Emerson, W. (1995a). The Vulnerable Prenate." Paper presented to the APPPAH Congress, San Francisco. Available on audio tape from Sounds True, (303) 449-6229. Emerson, W. (1993). Treatment Outcomes," Petaluma, CA: Emerson Training Seminars. Emerson, W. (1995/1996). Treating Birth Trauma During Infancy. A series of five videos." Petaluma, CA: Available from Emerson Training Seminars, (707) 763-7024. Laing, R. D. (1976). The Facts of Life. New York. Pantheon Books. Magid, K., &McKelvey, C. (1988). High Risk: Children Without a Conscience. New York: Bantam Books. AuthorAffiliation William R. Emerson, Ph.D. AuthorAffiliation Edited and elaborated version of same-titled paper presented at the 1995 San Francisco APPPAH Congress. William Emerson, Ph.D., an APPPAH Board member, is an internationally recognized authority on pre- and perinatal trauma. He conducts highly lauded seminars on his techniques. His videos on Treating Birth Trauma During Infancy are available from Emerson Training Seminars, 4940 Bodega Hwy, Petaluma, CA 94952.

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