Suicide and Pre-and Perinatal Psychotherapy

Author: Ward, Shirley A, MEd, DipEd

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Full Text: Headnote ABSTRACT: The relationship between negative events from conception to birth, and suicide, is explored. From extensive experiential work with clients, based on the work of the British psychiatrist Dr. Frank Lake, the author stresses that something else is going on in every death by suicide, that is not visible. Hidden factors relating to suicide have their roots in the pre- and perinatal period, from as far back as conception to the birth itself. Case studies are included and types of suicide correlated to various pre- and perinatal trauma are discussed. KEY WORDS: Prenatal and perinatal psychology, suicide, primal roots, pain, cellular memory 'Death by suicide is unnatural. Something else is going on in every death by suicide, that is not visible.' John O'Donohue (Divine Beauty Lecture 2004) INTRODUCTION Looking for that which is not visible, is at the foundation of pre- and perinatal psychotherapy when working with those who are suffering the excruciating pain that can be at the primal roots of suicidal tendencies. Since it was founded in 1982, Amethyst Resource for Human Development in Ireland has pioneered and researched the experiential work of over two thousand five hundred people reliving their journey from conception to birth. This has been experienced through the techniques of pre and perinatal psychotherapy, primal integration, regression therapy, energy healing, visualisation, meditation, art work, shamanic journeying, music, gestalt and other humanistic and integrative therapies. These methods have been used working side by side with the rapidly growing science of pre and perinatal psychology, which is dedicated to the in-depth exploration of the psychological dimension of human reproduction and pregnancy. This includes the mental and emotional development of the unborn and newborn child based also on the work of the British psychiatrist, Dr. Frank Lake. Evidence has shown that stressful pregnancies, traumatic births, and as far back as disharmony and conflict at conception, may hold the key to subsequent adult behaviour, relationships, attitudes, diseases we develop and the blocks that inhibit human potential. Within all these complicated issues of humanity are those of suicide and attempted suicide. It is my belief that at any point during the conception, pregnancy or birth, where the pain of the single cell, the blastocyst, the foetus, the preborn, is beyond the point of bearing, suicidal thoughts and tendencies take their roots. THE RETRIEVAL OF PRE- AND PERINATAL MEMORIES The retrieval of pre- and perinatal memories, from before and around birth, and including as far back as conception, can help us understand how and why we behave as we do in the world. The deep parenting and spiritual parenting of our own self discovery of those primal times begin to heal what might have gone amiss in the conception, gestation and birth from our physical parents. That conception, gestation and birth may have been wonderful or terrible. Remembering helps the re-creation of us. It creates the deep healing of what went wrong - and the deepening realisation of what went right. It is important to remember and experience the positive, in order to empower our whole being and to overcome negative blocks, which have hampered the development of human potential. Many answers are found in these periods of human development, the study of which are still in the infancy stage. Since his death in 1982, the work of Dr. Frank Lake is having a major impact upon the realms of pre- and perinatal psychology worldwide. He spent many years of his life exploring the realms of conception, and the first, second and third trimesters of life in the womb and the effect upon later personality and behaviour. Until recent years the common scientific practice has been to approach the earliest period of human development, from conception to birth, as a period of quiet time hi the womb, where nothing happens. The belief being that baby lives for nine months inside mother's womb, cosy and warm, protected and comforted by mother and father. Nothing could be further from the truth in many cases and neither is the belief that life begins at birth and not before. The Difficulty

of Verification For those who have not experienced this work and others who are deeply sceptical, and often misinformed, it is vitally important before continuing to look at the primal roots of suicide, that the general understanding and knowledge of how that which may be invisible to us from the very early times may be made known to us. The major question is so often asked how this cell consciousness, foetal memory or birth trauma can be real. The most convinced person is the one who has experienced the hidden places of life, from a primal place so far back, that it is difficult for them to comprehend. The experience has modified symptoms of major life difficulties profoundly. In the case of suicidal tendencies, having found them at source, the emotions and desire to end it all have dissipated in some clients. Once the place where the emotions originated has been found and the client realises that these feelings do not belong in the present day, there is great hope and often a positive behaviour change for the future. Verifying Cellular Memory Dr. Lake (1982) posed the questions of verification alongside the question of the embryological one. In the 1970's he was attempting to prove it was physiologically conceivable that the cellular and primitive body-brain functions of the organism at six to twelve weeks could cope with the complex tasks of findings from deep experiential work. Taking this all back to conception, Dr. Lake believed that it was possible that in the protein molecular structure of that single cell there is a capability to react to internal and external, good and bad, pleasurable and noxious stimuli. He stated that it was obvious to anyone who had studied the singe cell amoeba, that a single cell could do so much. In the 1970's Dr. Lake questioned, "when one cell divides into two and goes on dividing, as the genetic nucleus does, to reproduce the same coded information in all successive generations as a permanent record, does the cytoplasm do the same?" During the same period Richard Dryden (1978) was writing, "It is possible that the zygote contains information in addition to that stored in the nucleus. There is evidence that the cytoplasm of the fertilised egg contains information that is essential to at least the early stages of development. There are several sites where cytoplasmic information may be stored ... The abundant free ribosomes may carry developmental information ... The mechanism of protein synthesis lends itself to analysis by information theory ... the ribosomes helping to convert the coded message into a protein molecule." Molecules of Emotion Candace B. Pert PhD (1997) after years of research discovered the opiate receptor and many other peptide receptors in the brain and body, which led to an understanding of the chemicals that travel between the mind and the body. She discovered that the brain makes its own morphine, and that emotional states are created by the release of the chemicals called endorphins, shorthand for endogenous morphines. This pioneering research has shown how our internal chemicals, the neuropeptides and their receptors, are the actual biological underpinnings of our awareness, manifesting themselves as our emotions, beliefs and expectations, and profoundly influencing how we respond to, and experience our world. The molecules of emotion run every part of our body. In our world of the Establishment meeting the New Paradigm - the scientific answers are there for those needing them. In the pre- and perinatal areas of discovery this knowledge adds a vital understanding to Dr. Lake's theories of the maternal foetal distress syndrome, and F.J. Mott (1965) who named his theory, negative umbilical affect. In other words, anything that is happening to the pregnant mother, whether positive or negative, influences the foetus through the umbilical cord and the whole of the womb environment. Recent Advances in Cell Biology Science has indoctrinated us with the belief that the character and traits of our lives are programmed in the genes. Recent advances in cell biology now reveal that parental attitudes and beliefs profoundly influence the genetic programming of their offspring. The cellular biologist Bruce H. Lipton (1998) believes parental 'programming1 is first initiated in the formation of germ cells (egg and sperm) through a process called 'genomic imprinting". He has narrowed the split between the nature/nuture debate some 70 years after the Quantum Revolution of 1925 - seeing that major dualistic biological concepts are beginning to resolve themselves as parts of a whole - a unity. 'Nature' involves the concept of genetic determinism, the idea that plants or animals characteristics and behavioural traits are denned by the genes at the moment of conception (internal control). 'Nurture' the opposing view recognises environmental experiences as playing an essential role in shaping the characteristics of living organisms (external control). Dr. Robert Malenka advocated an end to the nurturenature

debate in 2000. He argued that owing to the advances made over the last decade, the dichotomies between nature and nurture, between biology and psychology are gone. It is now clear that environmental influences from learning to medications, modify thought and behaviour by modifying brain structure and functioning, most likely through changes in gene expression. What the pioneers and experiential practitioners of pre and perinatal influences were postulating and hypothesising, now has backup and this can make a vast difference in the understanding of where some of the roots of suicide and suicidal tendencies come from. Two Perspectives of Studying Birth and Intrauterine Memories Today researchers are studying birth and intra-uterine memories and movements from two perspectives. Firstly, scientific studies of the activities of the unborn and newborn baby are being documented, particularly the unborn, with the use of ultra sound scanning of the foetus in utero. So from before birth ultrasound is revealing the hidden life of the unborn baby. Major contributors documenting results from research are Dr. David Chamberlain (1998) and Dr. Thomas Verny (1981), and in his most recent and exciting work, Professor Stuart Campbell (2004), uses a new ultrasound technique called 3-D scanning. This uses the same ultrasound waves as the conventional scan, known to be safe in pregnancy, but collects the reflected sound in volumes which can be displayed in three dimensions. The image can then be updated three or four times each second, (called 4D), and the movements, facial expressions, and moods of the baby can be clearly demonstrated. The second perspective is that of birth and womb experiences relived by adults, children and babies in regression therapies or other bodyrelated therapies and hypnosis. It is through the experiential work that the following stories are told. HEALING SUICIDAL FEELINGS A case Study of a Client Working Between 1977 and 1980 This account has been written by a client working over 25 years ago - to show that the work lasts and is not only a short-term fantasy. 'On reflection I had a severe schizoid personality disorder. It caused me such great distress and pain that it was easier for me to cut off from the pain than allow myself to feel the suffering at a deep level. Consequently I lived my life at a superficial level and the pain was well hidden. But at times when it surfaced and became intolerable I wanted to die. I first attempted suicide at the age of thirteen with an overdose of pills. At the time I had no idea why I had done this - but parental illness, my own physical pain and family financial pressures caused intolerable responsibilities that I was too young to deal with. I had thought about ending it all, many times. My own regression work as an adult took me to the earliest places in my life when I experienced the primal pain of rejection through attempted abortion, more than once, and the most horrific forceps delivery that felt like it was severing my head from my body. I had no idea that my therapy would take me into these places and I certainly had no knowledge that the human organism was capable of remembering so far back. But the feelings that used to rack through my body every time I went into new situations took me into reliving my birth situation of rejection, fear and horror of not being wanted. I could relate superficially but wanted no closeness. I always sat close to doors and windows in a room -1 realised later it was a way of escape if people got too close. I often wanted help from others but spurned it. I felt I needed help but no way would accept it and became known as a very independent individual. But underneath the pain were intolerable feelings of rejection and annihilation - caused by the attempted abortions - which eventually led to very fast car driving, and car accidents, which thankfully involved no-one else, and did not kill me or anyone else, although unconsciously I now know the suicide attempts were there. I am aware that therapists may be filled with empathy and compassion but be baffled why a certain individual experiences herself at the core of her being as so utterly wretched and worthless. But finding out either from mother or the client experiencing what mother's feelings were, when she realised in shocked recognition that she was pregnant has had a terrible impact on the growing foetus. That this 'new life' was a disaster which mother both feared and hated intensely, and mother's feelings transfusing 'the foetus', who often is aware of being a loathed object, and not a person, are other places during pregnancy which have a devastating personality affect, all of which becomes projected onto present day life. My own feelings of suicide were illogical but after reliving the trauma and stress of the pregnancy and birth I realised there was a real place in life from where these feelings came. This was the healing. The change of behaviour came from knowing I was not mad. It was no-one's fault. There was no-one to

blame. At that time my parents did not know that anything negative that was happening in their lives was coming into me. I no longer have suicidal feelings because they do not belong in the present. I was meant to live - not die young. But if I had not learned the primal place where these feelings had originally come from I would have died by suicide over twenty- five years ago. I understand that with this prenatal distress percolating into adult life it is no wonder these early primal events are projected and cause suicidal tendencies.' 2003 A More Recent Experience of Discovering Where Suicidal Feelings Originate This young woman has only recently discovered where her feelings of suicide and wanting to die, originated. 'In telling you my story, and my struggle to both live and die, it involves the struggle to survive my inheritance from both my parents. My fight has been to break the cycle, not only for my sake, but also for the sake of my children. My mother had a history of difficult births, and I was the seventh. My mother's first delivery almost ended in her death. Her life hung in the balance for almost a week following an emergency caesarian. I was lOlbs llozs in weight and was delivered by forceps. In retrospect I lived my childhood in the shadow of fear. As I entered puberty, life was going to get worse. Life began to terrify me. It was terrible. My fear intensified and I was afraid to move in case I moved the wrong way. At the age of 16, a year after taking my first drink I began to suffer from depression. I couldn't figure out what was happening to me and I decided that life was not worth living and I had my first suicide attempt - overdosing on aspirin. I was in such emotional pain and didn't know how to deal with it. My only way of killing this pain was either to get drunk or overdosing. I married young and had two children. For seven years I spent my time at home pretending I was happy. I was far from happy and felt very trapped. I sank deeper and deeper into depression and became addicted to the antidepressants prescribed by my doctor. They blanked out what I was feeling- and the suicide attempts I experienced in my teens, resumed. Death was when I would have it made and I decided the only way out of my marriage was to kill myself. Two weeks before Christmas I went to bed taking over a month's supply of antidepressants. It was the first time I felt hope in a long time that death was my only hope. My suicide was unsuccessful and I woke up in intensive care two days later. My children lived with my husband -I left and attended the day hospital for treatment but ended up for a month in a mental home. I got a part time job and joined A.A. and went into counselling. I was grieving for my lost childhood and I wanted it back. The trauma I had experienced over the years could have a two-fold effect. It could be the catalyst for creative change or the cause of self-destruction. I had done the self- destruction bit -I was now ready for the creative change. I discovered whilst doing regression work that I spent nine months in my mother's womb being totally ignored by her. I felt my mother's reaction to her pregnancy such as ignoring me, hoping that I was a false alarm, and then anger towards me when she realised she was pregnant. Her reactions had a profound effect on my attitude not only towards her, but also towards how I felt about myself. I had nine long months to marinate in all this negativity and shame that my mother felt towards her pregnancy. Her lack of recognition led me to feel unwanted, rejected and shamed. My birth scripts, which became life scripts, were reading, 'I'm not wanted', 'I'm a mistake', and 'I shouldn't be here', 'I don't belong'. During my delivery my mother refused to help me being born, and my terror of being suffocated and dying in the womb resulted in me having a profound sense of anger towards her for trying to kill me. However, how was my mother to know that her own thoughts and feelings would have such a deep effect on me inside the womb? I myself was brought up with the knowledge that babies couldn't ever hear or see for weeks after being born, never mind being able to hear and feel inside the womb! It was very emotional for me to learn that these maternal attitudes and feelings could leave a permanent mark on the unborn child's personality. I feel tremendous gratitude that I am able to connect the fractal patterns in my life from conception to the present time. I feel my compulsion to die through suicide came from the trauma I felt in the womb and the feelings I was marinated in; my mother's feelings and mine, became all confused - 'I shouldn't be here', 'I'm a mistake', and 'I'm going to die during this delivery.' My way of attempting suicide through overdosing on medication can be connected to mom taking medication for her migraine and blood pressure whilst pregnant with me. I was recreating time and time again through events in my life, my time in utero and birth trauma. I feel certain that my mother's fear of death and dying came from

being conceived herself after her sibling died at the age of six weeks. She would have been marinated in her own mother's feelings of grief, and her fear of perhaps losing her own baby. By relating all of these fractals I am able to free myself from the destructive patterns at work in me. lean now differentiate what problems were mine and what problems were my parents'. HOW THE PROCESS WORKS In experiential psychotherapy, regression is part of a process of diminishing one's defenses against internal reality of pain and trauma. The stories included show 'how a person 'acts out' their preand perinatal dynamics in gruesomely overt ways of suicidal tendencies because the dynamics are so hidden, repressed and overlaid with defenses that the conscious mind has absolutely no access to, or insight into them being part of their unconscious dynamics' (Adzema, 1996). The conscious mind is then completely able to convince itself that these dynamics are actual and real parts of the situation and therefore require an actual, real and extreme response. Adzema explains that this can be brought about by a total dissociation from one's pre- and perinatal traumas - but the trauma is internalised and self-inflicted, and in this situation the suicide may be completed and death occurs. When there does not exist that total and complete dissociation of the pre- and perinatal trauma, and it is much closer to the surface, although still not in consciousness, it is more likely to be allowed to emerge into consciousness, be relived, healed and then removed forever as a motivation to end one's life. The Importance of Understanding Fractals Fractal patterns are all around us, above us and within us. They are repetitions of the same general patterns, even the same details, having characteristics of self-similarity and chaos. Trees are fractals, with their repeated patterns of large and small branches with similar details, found even in the smallest twigs. Even a single leaf shows fractal repetitions of the whole tree in both its shape and the branching in its veins. Fractal patterns may be seen in broccoli or cauliflower with florets arranged in self-similar scales; in the coastline of a country, or rocks, mountains and the patterns of the weather. The Fractal Events of a Human Life After being introduced to the concept of fractals by Jean Houston at the APPPAH Conference in Atlanta in 1991 (1996) I put the whole idea onto our work with pre- and perinatal psychology and psychotherapy. I thought if we looked at the events of a human life in the same way we looked at a tree, we might discover another order of fractals present in themes that recur in leafings and branchings of happenings, moods, personality traits, characteristics, positive and negative events recurring in life. It proved to be the concept we were looking for to explain recurring events that often went back to primal places. We found people were experiencing the unexperienced. They were understanding their lives were rhythms and patterns not only of the state of their parents before conception, but everything that happened to them during the pregnancy and birth. This is demonstrated in the two stories documented, there are many other stories. Fractals seem to be the descriptive link for the possible relationship between suicide and attempted suicide with negative events from birth and before. We have traced this back to negative and violent events in human lives. It may be the way our parents prepare or do not prepare for our conception; the state of our parents at our conception; the way we are in utero, the type of birth we have, which in turn will effect the way we live our lives and the way we die. The miracle is that we can often find the circuit breaker and change the negative patterns hi this process. QUESTIONS RELATING TO THE PHENOMENON OF SUICIDE AND PRE- AND PERINATAL THEORY I am aware that there are two very important questions relating to suicide to be answered by any theory that tries to explain the phenomenon of suicide (Grof, 1985). The first is why a particular person wants to take their own life, as it goes against the survival instinct. The second is the specific type of suicide chosen by the individual. Why Would a Particular Person Want to Take Their Own Life? When answering this question I believe that when working in the area of pre- and perinatal psychotherapy and psychology, relating to suicide, we see the patterns emerging from early experiences in a human life that prove to be a direct transcript of death being the only way out, and they have to do it themselves. At the time it may only have been temporary, but it was sufficiently imprinted at a cellular level for the person to have stored in their psyche, memory and consciousness, that they have to end their lives to find peace; they have to eliminate the unbearable pain; and the pattern is that they must kill themselves. There are many other reasons why a person wants to take their own life, but this is the reason we have found in the deep

experiential work. If it is not possible to survive, as the odds are too great against the organism, the only answer is to end life. Why is a Particular Type of Suicide Chosen by the Individual? Grof (1985) claims there seems to be a close connection between the state of mind a depressed person is in and the type of suicide contemplated or attempted. The thoughts may not only be to end one's life but to do it in a particular way. It is rare that a person would try different ways; a person choosing to take an overdose of tranquilizers would not attempt to jump off a cliff or under a bus or train. If suicide is ever seen as non-violent then there could be a differentiation, non-violent suicide and violent suicide. In our work the type of suicide appears to coincide or relate to the events experienced in early life, at a particular period of gestation or process of birth. It relates to the individual's response to the terrifying, horrific, unbearable events that the tender, helpless being - trapped in hellish pain, and too young to deal with such pain, splits off but the imprinting remains, only to be remembered when the person gets under terrifying or horrific stress in the future. Dr. Frank Lake's Four Levels of Foetal Response Frank Lake put on all stages of the birth process, four levels of foetal response. He stated that there was an ideally good level, in which the embryonic person was aware that the situation was satisfactory, and even if mother was not yet aware that she was pregnant, it was still going to be OK! Warmth, tenderness, caring and love were there to make a safe, and loving environment and give at a core level the necessary nourishment. Within this model Frank Lake also added his dynamic life cycle, that if a baby was accepted, this would lead to sustenance, status and achievement. When things went wrong it meant the life cycle was lived the wrong way round and a person could spend a life- time achieving to become accepted. The next level may be a coping response, when there was a failure to meet the essential foetal need for recognition at a level where the foetus loses hope of the 'ideal' and attempts to cope with the deficit or the distress, or both. This possibly could be the beginnings of the origin of depressive dynamics. The inability to handle the situation by coping, in the face of too severe, too prolonged, unremitting deficiency of maternal recognition of the foetal presence leads inevitably to the next stage, which is total opposition (Lake, 1982). Facing the terrible opposition of all that foetal life should be, the foetus goes into total opposition to the invasive maternal distress. Here may develop the suicidal tendencies, the feelings of badness, the bad is so bad that the need to leave the body is compelling. The person exists only outside the body, floating where pain cannot reach. Where the organism is driven by the sheer impossibility of keeping up the opposition to the invasive evil, which seems endless and relentless, the individual is thrust into transmarginal stress. It is here beyond the margin, stressed beyond bearing, the foetus longs, not for life, but death. It longs not for the relief of the burden, but hopes to be crushed out of existence. Everything to do with fighting for life has become too painful to look at and the only hope is to end it all. Lake would say that here is the root of the most determined refusal to seek life or let oneself be loved. The place of the deepest suicidal tendencies is here, as well as the roots of the schizoid personality, when the script is to never trust anyone. TYPES OF SUICIDE APPEARING TO COINCIDE WITH EVENTS IN THE PRE- AND PERINATAL PERIOD Remembering that this total opposition and transmarginal stress can be present right from the beginnings, in the conception stage where lust, anger, rage, rape, drunkenness, parental neglect, contempt and detachment may be present individually, or in some cases, multiple problems, and this can create a fractal pattern throughout life. Some people who are suicidal have never accepted their incarnation into life and into a physical body. They have never wanted to be here, some at a soul level, and have only wanted to 'return from where they came'. Difficulty in implantation, and a desperation to find a place to be, can culminate in never finding the right place to be, and the isolation drives the person to suicide, when in adult life the terrible isolation becomes overwhelming. This also links when mother finds out she is pregnant and the response is negative. The whole organism feels 'I shouldn't be here', 'It's all my fault', 'I'll end it as I'm the cause of her distress'. The loss of a twin in utero is more common than can be imagined, and mother may or may not be aware of this, but the remaining foetus does know. The guilt on the surviving twin is enormous and the blame is heavy. The desire may be to return where the twin has gone as the pain of separation is too great. Suicide attempts by an overdose of drugs may be related to drugs taken by mother during the pregnancy, or linked to

anaesthesia during the birth process. So much of the distress in the womb from external events, causes severe pain in the foetus. The invasion of the foetus by maternal distress, from the mother's often complex emotions is experienced by what Lake (1981) called the Maternal Foetal Distress Syndrome, and Mott (1965) called Negative Umbilical Affect. The suffering foetus states 'I'm in a dreadful place - I can't stand it', and so the suicidal tendencies are sown. Never so deeply as the survivors of attempted abortion, deeply aware of annihilation, rejection and therefore the risk of being 'wiped out'. This deep sense of not being wanted permeates into all areas of life and the desire to end it all is great. In regression the adult reliving the feelings of this suffering foetus, knows that its life is in danger and relives its own near-murder with quite shocking accuracy and overwhelming terror. Elisabeth Noble (1993) writes about the work of Canadian psychologist Andrew Feldmar (1979), who, as well as researchers at Loyola University in Chicago, found that some adults would attempt suicide at the same time each year. This was to do with timing, and these attempts turned out to be related to the month in which the mother had tried to terminate the pregnancy. The survivors also had used a method of suicide similar to the mother's abortion attempt, instruments or chemicals. Emile Durkheim (1951), the renowned French sociologist, in his classic book on suicide was looking at the timing of suicide with social activity. He declared that if suicide increases from January to June but then decreases, it is because social activity should be subject to an identical rhythm and consequently be more pronounced during the former of these two periods. He was looking at the patterns of the timing of suicide - and I would add, that the patterns of the social life of the parents be questioned also, with the timing of conception, pregnancy and birth. BIRTH TRAUMA AND SUICIDE The process of birth itself for most people may be tough, but tolerable. For others it may be devastating in its destructiveness. Cataclysmic muscular convulsions turn, in some cases, what would have been some type of peaceful haven into a crushing hell. The 'no exit' phase, before the cervix begins to open, can last for hours. The sheer horror of not being able to 'get out' instills thoughts of death being the answer to not feeling the pain. Intolerable pressures in later life may reinforce the suicidal thoughts. Frank Lake wrote (1981) 'The next phase of travel through the pelvis, is at best an energetic struggle, at worst a brain destroying, suffocating, twisting, tearing, crushing torture, in which the will to live may be extinguished and a longing to die takes its place. The hazards of obstruction, impactions, prolonged delays due to uterine inertia, or sudden violent extrusion when induction puts the uterine muscle in spasm, the hazards of forceps delivery, abnormal presentations, asphyxia as a result of the cord round the neck, breech births or emergency caesarian sections, all these possibilities of profound catastrophe may occur during this phase. The will to live has often turned here into a desperate desire to die.' Working with many of these events in adult regression in the therapy room over the last twenty-five years we believe the roots of some, if not all, types of suicide are to be found in the pre- and perinatal period. What has been produced is a lifelong imprinting of distressful feelings that have nothing to do whatever with the person's present life situations. It is a direct transcript, extraordinary, and in specific detail of the pregnant mother's disturbance, from conception to after the birth. In the birth process, the cord round the neck could lead to hanging in later life. In one case twins were born who were not wanted. The boy was born, and nearly died at birth with the cord round the neck. At twenty-one he killed himself by hanging. Also related to the cord, is the suicidal attempt of slashing wrists, which is a typical attack on a cut bloody cord. Two Scientific Studies Two scientific studies were done from which statistical data on the relationship between birth trauma and suicide were published. Both sets of results found birth trauma to be a high risk factor for later suicidal behaviour. Dr. Lee Salk (1985) found that teenage suicide was related to birth trauma. He discovered the most significant correlation of prenatal and birth conditions in the obstetrical histories of the suicides under study. Out of ten perinatal risk factors, respiratory disorder, absence of prenatal care and chronic maternal disease had the highest prevalence in suicides when compared to two matched control groups. Each of these factors occurred independently in 81% of the suicides studied. In the second study on suicide and birth trauma, Dr. Bertil Jacobsen and Dr. Marc Bygdeman (1987) discovered that a painful birth may make an individual more likely to die by violent suicide in adult life. Researching in Sweden they studied the records of 645 babies born

in the country between 1945 and 1980. Of these, 242 died by suicide by violent means between 1978 and 1995. They discovered that people who subsequently died by suicide were more likely to have been exposed to birth complications and were subjected to twice as many interventions at birth as their siblings, including forceps delivery. They stipulated that obstetric procedures should be chosen to minimise pain and discomfort to the infant as they might have a long term effect in adulthood. They also discovered that people who asphyxiated themselves by drowning, hanging or gas inhalations were four times more likely to have suffered oxygen deprivation at birth. A thesis on birth trauma and suicide produced by Jude Roedding (1991) in Canada, also surveys a number of studies linking suicide to birth trauma. Gaining insight into the pre- and perinatal period and using this knowledge is a powerful tool for understanding suicide and trying to prevent it. It provides individuals with an actual place from where their often intolerable and unbearable pain is coming. To even try to grasp the concept of the helpless, tiny foetus, being marinated into the powerful negative emotional struggles of parents and the outside world is almost inconceivable. But worldwide research is now showing that this is the case. CONCLUSIONS AND THE FUTURE It seems an incredible idea that people attempt suicide because something went wrong, either as far back as conception, or in utero, or with their birth process. Society is slow to recognise the importance of the primal period but the evidence of the power of imprinting from this time has increased dramatically over the last ten tears. Preconception care and the physical health of the unborn is an area where more knowledge is being given to new parents to be. Prenatal education and classes for parents go back many years - but there seems to be a gap in the care of pregnant women, probably more so in the Western world, than in the East where often the spirituality of a nation gives more energy to the developing baby. The major sin of humanity may well be ignorance - and this is the lack of information on the area of pre- and perinatal influence on later suicide and other post traumatic stress syndromes. Behind every death by suicide are hidden factors - and the unexperienced has to be experienced to find the circuit breakers, if this is possible with a client. Maybe the sceptics are those who have never experienced the depth of human despair and the desire to die. Being sensitive to the awareness of the pain of the client, who is in the tenderest of places, where the original pain occurred, and to believe that the client is referring to experiences that actually happened, is a responsibility we owe to them. Worldwide research is teaching us that we must expect serious consequences whenever foetal life has been subjected to maternal distress, addiction, domestic violence Gilliland and Verny (1999), abortion attempts and abuse during pregnancy. The self can die in a surviving body and lead to death by suicide. The human race has much to learn about the attitude to sex and caring relationships. There is a different dimension to be aware of, in response to the question why, in regard to suicide. The question as to why suicide occurs or is attempted need not go unanswered. It lies deep within the human psyche. Raising children who experience the minimal amount of trauma in the pre- and perinatal period will produce happy babies and self fulfilled adults. They will live in society without the desire to end it all. I hope that more research studies will be undertaken to look at the possible links between suicide and pre- and perinatal events. References REFERENCES Adzema, M.D. (1996). The scenery of healing. Commentary on De Mause's "Restaging of Fetal Trauma in War and Social Violence". Pre- and Perinatal Journal, 10(4), 261-272. Campbell, Professor Stuart. (2004) Watch Me Grow! A unique 3-Dimensional, week by week look at baby's behaviour and development inside the womb. Carroll and Brown Publishers Ltd. London. Chamberlain, D. (1998). The mind of your newborn baby. North Atlantic Books, Berkeley, California. De Mause, L. (1996). Restaging of fetal traumas in war and social violence. Pre-and Perinatal Journal, 10(4), 229-260. Dryden, R. (1978). Before birth. Heinemann. Durkheim, E. (1951/1966). Suicide. A study in sociology. Free Press, Macmillan Company. Eliot, L. (1999). What's going on in there? How the brain and mind develop hi the first five years of life. Bantam Books. Feher, L. (1980). The psychology of birth. The foundation of human personality. London: Pd Souvenir Press. Feldmar, A. (1979). The embryology of consciousness. What is a normal pregnancy? In D. Mall &W. Watts (Eds.), The Psychological Aspects of Abortion. Washington, DC: University Publications of America. Fodor, N. (1949). The search for the beloved: A clinical investigation of the trauma of

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