Birth Trauma and Suicide: A Study of the Relationship Between Near-Death Experiences at Birth and Later Suicidal Behavior

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Full Text: Headnote ABSTRACT: The relationship between birth trauma and suicide is discussed. A critique of psychoanalytic theory is presented. A number of studies linking suicide to birth trauma are surveyed. A synthetic theory of this relationship is described and the positive role of therapy in resolving birth trauma-related conflict is explored. The classic model for exploring the dynamics of suicidal behavior is the Psychoanalytic approach and is defined in the National Task Force on Suicide Report1 as dealing with suicide from a client's internal perspective which comes closest to my approach in this article. Suicidal "depression" is considered by psychoanalysts to be a determining factor for the eventual act itself with various internal states manifested externally in suicidal behaviour.2 These internal states are referred to in psychoanalysis as "motives".3 The motives or states that coincide with my findings on this matter will be elaborated on later and include: "control"4 (where taking one's own life is considered a final act of "free choice"); "escape from an intolerable situation, pain or panic"5, and the "inability to conceive alternative actions to death"6. Psychoanalysts view high risk patients as having a dynamic internal process that gradually drives them towards suicidal behavior.7 It has been concluded that, although environmental circumstances may provoke a suicidal act, as Emile Durkheim's Statistical Social model suggests (1951)8, the substance for suicidal feelings and thus the focus for treatment, is intertwined with the psychodynamics at play within the "hidden" or repressed realm of the person's unconscious and, therefore, internal experience: The suicidal drive in the last analysis is from within the individual, rather than from without. Suicide is the terminal act in a complicated psychic drama, the final response of a person to his own needs, desires, and circumstances. External events may precipitate that act, and in certain circumstances such as mass suicide in the face of persecution, may dictate it. Countless persons faced with what appear to be the same provocations do not commit suicide. The primary impulses which lead to suicide lie hidden in the depths of the individual's personality.9 In 1985 and again in 1987, for the first time in history, two scientific studies10 were published formulating statistical data on the relationship between suicide and birth trauma. Both studies found birth trauma to be a high risk factor for later suicidal behaviour. In fact, birth trauma was found in one study11 to be the highest risk variable out of 46 variables, including social and environmental factors. In the first study Dr. Lee Salk12 (1985) discovered that the most significant correlation made leans toward prenatal and birth conditions in the obstetrical histories of the suicides under study. He found that out of ten perinatal risk factors, three (respiratory distress, absence of prenatal care and chronic maternal disease) had the highest prevalence in suicides when compared to two matched control groups. Each of these risk factors were significant enough to occur independently in 81% of the suicides studied. In the second statistical study on suicide and birth trauma, Dr. Bertil Jacobsen13 (1987) found more specific correlations between methods used to commit suicide and specific birth imprints. Asphyxiation during birth, for example, was noted as being four times higher in suicides by strangulation, hanging and drowning than in control groups. Likewise, mechanical injuries during birth involving the head and neck, which Jacobsen categorized as forceps deliveries, breech births and knotted umbilical cords, were present in twice the percentage of suicides as in the controls. As early as 1933, researchers14 recognized that suicidal people, more often than not, had a specific method determined with which to take their lives. Moreover, it was found that, no matter how inaccessible or how long it took to access, the suicidal person would not deviate from his/her chosen method. Dublin and Bunzel15 reported that, aside from "accessibility" and the "power of suggestion" (by others who previously attempted

suicide), the most important factor that determines a chosen method is "psychological": The physician should constantly bear in mind this important fact connected with the suicidal disposition-viz., that those determined upon self-destruction often resolve to kill themselves in a particular manner, and however anxious they may be to quit life, they have been known to wait for months and years, until they have had an opportunity of effecting their purpose according to their own pre-conceived notions... A morbid idea is frequently associated in the maniac's mind with a particular kind of death.16 This report gives an example of a suicidal patient who feared his own self-destructive impulses when in a situation where the method he had formerly contemplated in a suicidal state of mind was present. [Another] example was the case of a depressed patient who would not trust himself in an outside stateroom when crossing the ocean, because he feared he would be tempted to throw himself out of a porthole. It never struck him that a far simpler method of achieving the same end would be to throw himself over the deck rail...17 It appears more plausible, in the context of birth trauma, that the "porthole" method was the only one this patient could perceive in lieu of more obvious alternatives because the circular and small nature of the porthole represented the unconscious memory of the birth canal. Aside from the birth metaphors in the above example, these early investigators had touched on a significant aspect for the study of suicide. When we consider their findings, that psychological factors are at the root of determination of methods used, we are at least directed more deeply into the human psyche for the source of the suicide's rigid determination of methods. Birth has been universally symbolized as a form of dying. Some researchers propose that the near-death experience of birth is portrayed in mythological stories about serpents and dragons and death/rebirth rituals and through some expressions of art.18 This dying reflects a biological transition from fetus, living in a dark, liquid environment, to a newborn suddenly thrust into light and direct contact with other beings. In Life Against Death, Norman O. Brown writes: The purely biological act of birth, . . . is in itself the death of a fetus as well as the birth of a baby.19 It is the varying severity of nearly dying at birth that differentiates the degree and nature of behavioral acting out for suicidal and non-suicidal persons. Dr. Frank Lake, British theologian and birth regression specialist, describes this difference with respect to the disparity within birth experiences: . . . although for most people the process of birth may be tough but tolerable, for some it can be devastating. Cataclysmic muscular convulsions turn a peaceful haven into a crushing hell. This 'no-exit' phase, before the cervix begins to open, can last for some hours. 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 take its place.20 In 1949, Nandor Fodor, Freudian analyst and advocator of the validity of birth trauma as repressed memory, wrote that . . . the fear of death begins at birth. We have no conception of what death is until we experience it; but we have all experienced birth, and if the fear of annihilation had not been overwhelming, the experience would not have been barred from our infantile consciousness. Nature has seen to it that the memory should be repressed. Locked up in the depths of the unconscious mind is the terrific impact of birth, the violent adventure that uprooted our pre-natal world.21 Fodor suggests that "we have no conception of what death is until we experience it". In essence he is saying that we only know that which we have already learned from a previous experience. Leslie Feher, birth psychologist, likewise says that: Fear of death, in short, does not exist. We can only be afraid of that which we have experienced.22 Brown describes birth anxiety in relation to a near-death experience: The anxiety of the infant at birth, when life and death are struggling with each other, is the model for the syndrome of physical sensations and innervations which accompany later outbreaks of anxiety.23 If the prototype for anxiety is the trauma of birth, as Sigmund Freud once indicated24, the psychodynamics involved in that process would naturally entail a prototypic fear of dying as one once knew it. In the same vein, adult anxiety, triggered by events which bring the person back to that infantile state Freud called the "original helplessness of human beings"25, would also extend back to repressed memories of a life and death struggle at birth. Stanislav Grof says that anxiety ... is a logical and natural concomitant of the birth process in view of the fact that delivery is a situation of vital emergency involving extreme physical and emotional stress.26 Everyone suffers anxiety to

varying degrees of intensity. The more intense the anxiety the more difficult it would be to cope with. In his book, the Problem of Anxiety, Freud questioned the dramatic differences in adults for coping with their anxiety: One cannot escape the thought, indeed, that the very nature of danger has a bearing upon the fact that the affect of anxiety is able to command pride of place in the mental economy. But the dangers in question are those common to all mankind; they are the same for everybody; so that what we need and do not have at our disposal is some factor which shall enable us to understand the basis of selection of those individuals who are able to subject the affect of anxiety ... to normal psychic control, or which on the other hand determines those who must prove unequal to this task.27 Had Freud been more vigilant in expanding the concept of birth as the prototype for anxiety, and had he incorporated birth trauma as a distinct repressed experience as his colleagues Fodor and Rank28 had, the differences in how people cope or do not cope with anxiety would have been better answered. When considered in the context of the birth struggle it is obvious that anxiety levels will naturally differ according to the intensity and prolongation of the trauma. Rollo May, an existential psychologist who studied the ontological nature of anxiety once wrote that, "Anxiety is the state of the human being in the struggle against what would destroy his being".29 Clearly, anxiety, a non-specific term for the stress of fear and the prototypic feelings from birth, is a repressed, and therefore unresolved traumata from a struggle against death, against that which once threatened to destroy one's life. A related aspect of birth and death deserves brief discussion before I proceed with the suicidal aspects; it is the phenomenon of perithanatic experiences of adults as they correspond to the final stage of birth. In view of the fact that anxiety originates from the experience of life against death at birth, another condition of this early experience is revealed by people who have died and come back to life. This phenomenon, documented in text, (Ring, 1982 30; Moody, 1976 31) appears to represent, symbolically, the very last stage of birth, the point at which the fetus exits the birth canal and dramatically enters the ethereal world of adults. The often unbearable struggle through the experience of dying is finally over. The third stage of birth represents a radical shift in the focus of a fetus' consciousness. Carl Sagan, scientist and writer, gives an extensive portrayal of what this "grand entry" must be like: Stage 3 is the end of the birth process, when the child's head has penetrated the cervix and might, even if the eyes are closed, perceive a tunnel illuminated at one end and sense the brilliant radiance of the extra-uterine world. The discovery of light for a creature that has lived its entire existence in darkness must be a profound and on some level an unforgettable experience. And there, dimly made out by the low resolution of the newborn's eyes, is some godlike figure surrounded by a halo of light-the Midwife or the Obstetrician or the Father. At the end of a monstrous travail, the baby flies away from the uterine universe, and rises toward the lights and the gods.32 Near-death experiences of adults include people who, during major surgery, for example, went into cardiac arrest or similar life-defying circumstances which caused a dissociation of consciousness from their bodies. Such people have described the sensation of being in a "dark tunnel"-of seeing an "intense light" and a "divine" figure in the midst of that light. A patient who went into cardiac arrest describes his experience: Well, it seemed at that particular time, when my heart died, I seemed to go up into a spiral in a deep black, pitch black tunnel ... I saw nothing. It was just pitch black.33 Spirals and deep black tunnels have been found by professionals to be common metaphors for birth.34 Kenneth Ring, scientific investigator of perithanatic experiences, has found that dying consists of five stages: Peace, Body Separation, Entering the Darkness, seeing the Light, and Entering the Light.35 Interestingly, the end of the third stage of dying, "entering the darkness" and the beginning of the fourth stage, "seeing the light", compares to the third stage of birth, and is marked by a passing from the darkness of a "tunnel" (darkness in the birth canal) into a "brilliant" light (delivery room). Often, in the midst of this light, subjects report a "divine presence", which corresponds to the person at the vaginal opening where the newborn had his/her very first contact with another human being. When life has been restored, perithanatic subjects believed their unconscious imagery to reflect a "life after death". Ring states that In the minds of at least some of our respondents, the transition from darkness to light is packed with symbolic meaning... it is taken to signify the termination of the experience of dying and the beginning of a new life.36 Freud propounds

on the concept of life after death within the context of repressed birth memories: It was not for a long time that I learned to appreciate the importance of... unconscious thoughts about life in the womb. They contain an explanation of the remarkable dread that many people have of being buried alive; and they also afford the deepest unconscious basis for the belief in survival after death, which merely represents a projection into the future of this uncanny life before birth.37 It is difficult not to be curious about the similarity of perithanatic experiences occurring repeatedly in different cultures and in a wide range of life-threatening circumstances.38 These similarities may have a significant metaphoric relationship to the one most universal experience for all of human life, the act of being born. Sagan asks: How could it be that people of all ages, cultures and eschatological predispositions have the same sort [original emphasis] of near-death experience?39 Is it possible that the commonality of near-death experiences triggers a commonly repressed memory from a previous experience-a state that can only be remembered in the deepest layers of unconscious levels of experience? Dr. Raymond Moody, perithanatic researcher and author of Life After Life40, confirms these deep-seated similarities of neardeath experiences as they range across a broad continuum of diverse situations and people: Despite the wide variation in the circumstances surrounding close calls with death and in the types of persons undergoing them, it remains true that there is a striking similarity among the accounts of the experiences themselves.41 Is it also possible that the repressed memory of birth is a precursor for perithanatic experiences? When we consider Fodor's notion that individuals "have no conception of what death is until we experience it"42 one can be so bold as to speculate that perithanatic experiences have already been imprinted from a previous learning experience associated with death. Sagan, with undaunting assurance, posits this exact notion when he says: ... every human being, without exception, has already shared an experience like that of those travelers who return from the land of death: the sensation of flight; the emergence from darkness into light; an experience in which, at least sometimes, a heroic figure can be dimly perceived, bathed in radiance and glory. There is only one common experience that matches this description. It is called birth.43 In Otto Rank's44 explanation of the need to re-enact the birth trauma, he adds that the need to return to the paradisal womb feelings that presumably existed previous to the trauma is also an unconscious desire for re-enactment and represents a "double barrier of repression"45 and a "primal ambivalence"46: Times of external distress, which remind the unconscious too strongly of the individual's first affliction in life, namely, the birth trauma, lead automatically to increased regressive attempts which must again be given up, but just because they have approached too near to it and have come up against the primal anxiety ... So the primal tendency to reestablish the first and most pleasurable experience is opposed not only by the primal repression acting as a protection against the repetition of the most painful experience associated with it, but simultaneously also by striving against the source of pleasure itself, of which one does not wish to be reminded because it must remain unattainable.47 Rank's concept of "primal ambivalence" reflects a paradoxical phenomenon of two conflicting primal needs-the need to return to the peaceful qualities in the womb, and the need to re-enact the trauma of one's birth for resolution. In the autobiography of a woman who attempted suicide many times, Mary Savage48 exposes this conflict when describing how she felt in the midst of her desire to die: As I sat on the sand, sounds floated past without touching me and my presence sifted away into the sea. The sea was my mother, my torment and my peace, and I longed to be united with it.49 The inner conflict of the need to repeat the birth trauma, in an attempt to resolve the dying experience at birth, against the background of an unconscious desire to return to the security and bliss of mother's womb, is portrayed in the psychoanalytical field when Brown discusses Freud's concepts of human "destiny": For Freud as for St. Augustine, mankind's destiny is a departure from, and an effort to regain, paradise; but in between these two terms man is at war with himself . . . 50 It appears this deeply rooted "war" is resolvable and that the "paradise" is attainable. Through re-living the trauma of birth, one can also regain the memory of the pleasurable womb-qualities, so that, as Otto Rank had not yet observed, the womb pleasures are retrievable. Considering the relationship between birth and suicide we may now ask the question: "Are the memories of a womb-paradise and the bittersweet end of the near-death struggle in the last stage of

birth associated memories that are compounded within the repetition compulsion of the desire to die? Considering Otto Rank's postulation of the concept, "primal ambivalence", and the evidence of birth metaphors in perithanatic reports that exemplify a common similarity across cultures and life-threatening circumstances, this question is significant. Another area of research involving the notion of dying and its connection to birth comes from Stan Grofs LSD therapy51 experiments with subjects who were dying of cancer. During their sessions, while expressing personal experiences of what it is like to be dying, subjects regressed to revivications of dying during their births. After numerous occasions of observing the subjects' experiential interconnections between dying in the present and dying at birth, Grof and his colleagues concluded that, at least for some, a present inner experience of dying (i.e., with cancer) triggers unresolved memories of the near-death pain associated with birth: We believe that the struggle and agony that are associated with dying in some persons are due to the fact that the physiological and biochemical changes in the organism activate painful unconscious material from the individual's history that has not been resolved and the imprints of the agony of birth that have not been worked through and consciously integrated.52 Norman Brown, in his study of Freudian doctrine, touches on death as related to birth in a rather off-handed way: "... only he who can affirm birth can affirm death, since birth and death are one."53 Brown's statement, although reflecting a philosophical musing, comes close to the personal historical truth of the interrelatedness between birth trauma and later dying experiences. Perhaps the profundity of this relationship can be summarized in a very simple statement that Nandor Fodor once made: "In its shattering effect, birth can only be paralleled by death".54 PSYCHODYNAMIC MOTIVES FOR ATTEMPTING SUICIDE Three of several underlying "motives" which psychoanalysts have found to precipitate suicide attempts as viewed by the author in the context of their relationship to birth trauma are: "escape from an intolerable situation"; the "inability to conceive alternative actions to death," and "control-the final choice".55 Suicide as an Escape The most obvious motive for suicide is the escape death offers from painful experiences in life. As much as suicide may be seen as an "escape", however, it is experienced by the individual as the only relief in sight from his/her current dilemmas. Suicide is, indeed, an escape. The crux of this matter, however, is that death was literally an escape in the very beginning of a suicidal person's first encounter with struggle during his/her birth. The struggle for some was so overwhelming that it became intolerable and close to complete annihilation of life. The unending pressure, literally squelching the last efforts to live, was "escaped" from through those dying moments-moments that must have brought relief that the overwhelming struggle was finally ending as the birth canal "tunnel" of darkness consumed the life of the fetal body-moments that taught the child dying was the only escape from unbearable and seemingly unrelenting pain. Savage writes about this "escape" from intolerable pain and "pressure" and refers to it as an "addiction": . . . the highest group for successful suicide is among those who have tried it before. Attempted suicide does become an addiction, a desperate means of coping with unbearable pressure and apparently irremedial pain.56 No Other Alternative From within the constricting confines of the maternal birth canal, the fetus endures the most climatic and violent stage of the entire birth process. The experience in the birth canal can be a devastating and hopeless one, to say the least. Crushing from the constriction of the vagina, suffocation from prolonged pressure on the cord, forceps clawing at a delicate and vulnerable head, drugs rendering the fetus limp and even more helpless are only some of the many variables for the imprint of a near-death memory. In a dream from a patient Fodor treated, metaphors and dream symbols reveal semblances of this struggle: I was going either through a long passage or up some stairs or through a door; maybe I was doing all three things. Every step of the way was a struggle. I fought and pushed. I don't know whether I was too fat or whether something was holding me back. Finally I reached the top of the stairs. People were there watching me. One of them reached out a hand and helped me to squeeze myself up. I felt free when I got into the open.57 When the birth is particularly difficult, the entrapment and helplessness in the struggle leaves an associative memory that, in adulthood is reflected by one's belief that there is no other alternative to coping with stressful situations than to die-dying having been a literal alternative to the violent struggle during

birth. Janov supports this notion: . . . death as a solution to current pain stems from a prototypic traumausually around the time of birth-in which death was the only solution. The notion of death as the only way out then becomes fixated in the system as an unconscious memory, shaping the way a person thinks about solutions to overwhelming problems later on.58 The helplessness in the birth canal is inherent within the belief that "there is nothing I can do but die". Stan Grof59 describes birth entrapment as an intolerable situation where it is impossible to protest and discharge the accumulating emotional and "motor" responses. The experience thus gets absorbed back into the fetal system where it remains as a highly charged memory: . . . the child trapped in the narrow confines of the birth canal has no outlet for the flood of emotional and motor impulses, since he or she cannot move, fight back, leave the situation, or scream. It is therefore conceivable that an enormous amount of aggressive impulses and general tension would be, under these circumstances, fed back into the organism and stored for belated discharge.60 The memory locked deep in one's unconscious experience gets displaced behaviorally in a "belated" release of its repressed emotional content in situations that symbolize and thus activate, the original trauma: The desire for death ran through my life like a deep sub-current, mostly invisible but powerfully present. Now and again it surfaced, triggered by some circumstance . . . 61 It would seem that any stressful circumstance encountered by an individual predisposed to suicide would trigger the prototypic anxiety of the birth struggle and, therefore, the prototypic response, dying. Janov62 explains that a repressed memory contains the old feeling and the old response, so that, in situations that elicit repressed material, both the emotional pain and the response to that pain are re-played. Whenever a pain is engraved into the nervous system, the response to that pain is also stamped in. Thus, prenatal and natal traumas have both a quantitative and qualitative effect. There is the input or overload (quantity) of pain which is registered and processed on lower levels of the brain; and a registration of the response to that input (quality)-which becomes fixed and determines the type of behaviour later on. The pain and the response are a unity which becomes prototypic so that under later stress the original response pattern is automatically triggered.63 It makes sense that when the pain of birth produces a feeling of struggle which becomes so severe that one experiences the sensations of dying, one retains memories of all the surrounding nuances that went along with the learned association of dying as the response to overwhelming stress. The memories are transformed into metaphorical language as when a suicide says: "There is no other way out but to die". Indeed, in the birth canal, there was "no way out" except through the process of dying before finally exiting the canal. Suicide is the only alternative to emotional pain because it actually was the only alternative at birth, following the overwhelming battle to live. A suicidal woman remarks on how, no matter what a well-intentioned friend or psychiatrist might say of "other alternatives", she could see only one-it was, without any question in her mind, death. While I was suicidal, any suggestion that I could get better or that there were alternatives was almost automatically transformed into a reason for killing myself. The road I walked went only one way, and signs pointing out roads going in other directions were not only ignored, they were not even seen.64 A person who feels helpless to resolve and deal with emotional responses to life difficulties may eventually narrow his/her choices down to the deepest most prototypic alternative ever encountered in his/her life. Feher says that: When all of life seems unresolvable and all defense useless, the individual turns more and more to past traumas, birth being the last world-connected experience.65 Present dilemmas in life that add to the normal stresses of daily living, appear to be the foremost triggers, in general, for suicidal acts. It is obvious the life and death struggle in the birth canal is overwhelming when it is endured to the point of near-death and defeat. And, where others strive to cope with major difficulties, suicidal people lean towards hopelessness and dying as the only way to cope. The compulsion to die, says Janov, ... occurs when overwhelming events in the present leave one feeling hopeless: the loss of a long-held job, failure in school, the death of a loved one, divorce, separation, illness, etc. These current life traumas activate residual birth feelings so that a situation that should be viewed as difficult or stressful is now viewed as hopeless and impossible. Instead of feeling sad, frustrated or depressed, the person feels suicidal.66 Therapists who specialize in abreactive and age-regressive techniques find that no amount of talk or pleading

will change a suicidal person's intentions. The individual's perceptions are clouded by unconscious memory- dying at birth is re-experienced on a very deep level and consciousness connects to the affect without knowing on a cognitive level where it comes from. The memory is a highly charged, preverbal experience that sadly directs the behaviour and acting out of the old trauma. The suicidal person can only feel the repressed trauma- no words or pleading can change this deeply felt experience. Janov emphasizes the fallibility of verbal attempts to change the mind of a person at the brink of discharging a memory of dying: The system [psyche] always veers toward its imprint. One may talk away, exhort away, plead away those tendencies, but the minute the exhortations stop the system veers again toward the disconnected memories of death-memories that reside in brain tissue deep down in the nervous system and have nothing to do with words or concepts.67 In the behavioral "disguise" of a repetition compulsion and, it appears, at any cost, the conscious mind seeks wholeness and completion through connecting to unconscious material in attempts to resolve old, emotionally charged traumas. Control- The Final Choice One of the motives common to suicide is the need to exert "control" through choosing to take one's life. Considering the helplessness and lack of control for the fetus during a near-death struggle during birth, it makes sense that later behaviour reflecting personal control over one's life by choosing to die reveals an attempt at resolving the birth pain. Perhaps the most profound control and power we have as humans is the choice to die and leave this world behind. When we are stripped of all else (dignity, love, power, purpose), the bottom line for control may lie in the final choice left to us, to take our own lives. For some of us this choice comes close to actuality. The helplessness of nearly dying at birth may be compensated for by the power inherent within the choice to control one's death. If I could not be omnipotent, then I would be powerless. But even in my impotence, I wanted control, so I tried to show I could control my life by dying.68 Choosing to die is a profound way to "master" the prolonged helplessness during birth and reverse the old circumstances. Janov69 writes about a client who relived the dying struggle during his birth and came to realize how his suicidal behaviors were actually attempts to conquer the helplessness: [A] patient came out of his birth primal with the insight that suicide was his means of conquering death. He had always had an inner feeling of foreboding and doom, and the thought of suicide was his self-assurance that he could control the ultimate doom: 'Death is not going to come and get me-I'm going to get it!' It was his way of conquering the helplessness of the agonies around birth.70 Amidst all of these unconscious motives there seems to be one all-pervasive feeling for the experience of someone contemplating suicide and this is the feeling of hopelessness. This feeling especially underlies the "escape" and "no other alternative" motives and shows itself time and again in statements such as: "It's no use going on"; "I just can't make it"; "Life is too painful;" "I give up"; "I can't do it anymore"; "There's no way I can get through this", and so on. Belkin71 describes the experience of suicidal clients: Usually the client is suffering from a feeling of overwhelming helplessness and futility, the belief that nothing can help, nothing can make a difference. He or she feels closed in, confined in an unbearable situation from which there is no escape.72 Feeling "closed in", "confined to an unbearable situation", are clearly birth metaphors. In anyone's daily life, unbearable situations are dealt with by simply leaving. When the suicidal person feels trapped in difficult life circumstances and cannot see other alternatives, it becomes apparent that deeply repressed birth pain is revealing its indelible mark on his/her attitude of hopelessness. The futility of these feelings reflects a "no-win" struggle, the individual cannot see the "light at the end of the tunnel" (birth canal), or an end to the unbearable pain, while complete and utter hopelessness takes over. Michael Holden73 believes the futile nature of hopelessness to reside in the last stages of birth when the frantic struggle of the fetal organism is lost to what he calls "body fail"74. The compelling response is a giving up when the fetus surrenders to the impossible struggle. Holden says that the catharsis of these feelings show: . . . a sense of increasing futility and emotional paralysis revealing itself in the attitude that all attempts to change the course of the trauma or the feeling are impossible.75 In the state of complete hopelessness the terror of dying is gone and replaced by the serene sense of surrender. However, as Holden has seen, "it is simultaneously an abjectly hopeless and helpless state".76 He called this condition a state of "death awareness".77 Holden also found that

when a client regressed to the "body fail" stage of dying at birth, his/her pulse rate dropped to 40 beats per minute while body movements showed a decline in motor actions. Remarking on this observation he says that body fail is "partially defined by . . . an increasing sense that the limbs are heavy and harder to move".78 The giving up of the struggle against death and the state of hopelessness that seems to naturally follow was, at the time of birth, a necessary option. The fetus had no other choice but to given in to dying when his/her organism could no longer withstand the prolonged assaults. Janov adds that suicidal feelings are embedded in a memory of hopeless defeat, in there being no way out, no way to succeed, no way to fight back. One solution remains-death.79 Repressed feelings are constantly displaced in the present, diverting them from their original source. As Janov puts it, the unconscious emotion, has left its precise home and wandered toward other places where it adheres ... [and] the energy . . . becomes an enduring force that must find an outlet until it achieves resolution.80 RESOLUTION Discussion of the resolution of severe near-death feelings from birth first necessitates a brief overview of bodily expressions of repressed emotions as they relate to birth regression work. Emotional trauma is not only repressed by way of the nervous system, as Janov postulated, but in the muscle systems as well81. The latter is clearly a necessary therapeutic aspect for accessing pre-verbal birth memories due simply to the fact that the body of a newborn child is the only medium for experiencing and expressing pain. Calvin Hall 82 has deduced that: ... most of the prototypic experiences involve the body because the baby is more concerned with body functions ... 83 A newborn actively responds to stimuli such as pressure, warm and cold, rough and soft. When any kind of discomfort is experienced the newborn's main form of expression is to cry. It has been found that different newborn cries can be distinguished by the nature of the pain being experienced. Crying is the primary method of communication in newborn infants ... Several studies have classified infant crying according to the type of distress indicated and its spectrographic properties. These studies have shown that cries due to pain, hunger, or fear can be distinguished reliably by the subjective evaluation of trained observers and by spectrographic analysis. This has allowed the cry response to be used as a measure of pain in numerous recent studies.84 The motor responses of newborns, although limited, are clearly exhibited by the flailing of arms and legs when severely distressed. Greenacre85 discusses a scientist's observation of the motor behaviour of a newborn expressing "rage": ... 'rage' is indicated in the newborn infant by 'stiffening and fairly wellco-ordinated slashing or striking movements of the hands and arms. The feet and legs are drawn up and down ... Almost any child from birth can be thrown into rage if its movements are hampered; its arms held tightly to its side, or sometimes even by holding the head between cotton pads.' Here I would emphasize that this behaviour appears as an aggressive reactive response to situations which are at least faintly reminiscent of the recent birth experience, in which the child was perforce helpless and the victim.86 Since bodily expressions are the most accessible medium for interaction by the infant, it would also hold true for an adult regressing to infantile traumata, particularly the biological nature of traumatic birth material. The prototypic pain of birth can only initially be expressed by the adult, therefore, through bodily sensations associated with the precognitive prototypic feelings. When it is seen that the experiential quality of external stimuli for the newborn is felt with his/her body, and that the only medium for expression of the inner experience is through bodily movements and crying, it follows that the pre-verbal nature of the trauma of birth is a bodily repression. The retrieval of birth memories for curative abreaction in the adult reliving birth, therefore, will initially come through body sensations followed by obstetrical movements for completing the birth sequence. Is the body memory a psychobiological link that predetermines an individual's choice of method to kill him/herself? The choice of physical methods for the suicidal victim appears indicative of just that. In the case of cord strangulation, Holden explains: The reported responses of patients during Primal Therapy suggest that such memories are formed ... Each body part is woven into integrated function by the action of the nervous system. It would be nonrational to say that the trachea 'remembers' transient strangulation during birth, but there is neuroembryological evidence that the functioning unit of trachea and newborn nervous system is a reactive, adequate system; one potentially capable of 'learning' from an exceedingly intense stimulus.87 Grof

provides specific clinical correlations between methods chosen and psychobiological memories of birth pain: ... I have repeatedly observed that the individuals who were contemplating a particular form of suicide were already experiencing the physical sensations and emotions that would be involved in its actual enactment. Thus, those persons who are attracted to trains ... already suffer from intense feelings of being crushed and torn to pieces; it is easy to trace these feelings back to perinatal experiences. Those who have a tendency to cut or stab themselves complain about unbearable pains in the parts of their bodies that they intend to injure. Similarly, the tendencies to hang oneself are based on strong and preexisting feelings of strangulation and choking. Again, both the pains and choking sensations are easily recognizable as elements of the third perinatal matrix, [third stage of birth in the birth canal]88 Savage writes about the experiential qualities in her longing to die giving vivid clues in birth metaphors when describing her overall bodily feelings: My trap is my body itself, which is a heavy thing, lifeless and stupid, pulling me down into a dull, grey fog. The only way out is to get rid of it.89 For Savage, the therapeutic "way out" is to experience the "heavy" lifelessness within that "dull, grey fog" in her body and express those sensations in a regression to the prototypic trauma that imprinted the bodily memories in the first place. As Savage explored more deeply the images associated with her body's internal experience she touched on the fear in the birth canal with "tube"metaphors: I acquired two important bits of knowledge about myself . . . The first concerned a fear of tubes . . . tubes too small to stand up in.90 It is interesting that the prologue of Savage's book, Addiction To Suicide, is a quote by Martin Luther commenting on suicide which typifies cord strangulation during birth: It is very certain that, as to all persons who have killed themselves, the Devil put the cord round their necks . . . 91 It appears "very certain" to the author that Martin Luther's "devil" is a birth metaphor describing a time when, by virtue of the nature of the upheaval in the womb or the struggle in the birth canal, the umbilical cord was displaced around the neck of the fetus. When an emotional charge is so powerful that it elicits behavior as self-destructive as suicide, the emotion itself has to be dealt with. Instead of expending the energy of the repressed feelings through "displacement" and "acting out" in external areas of the individual's life, abreaction directs the individual to the internal nature of the feelings and their associated memories. This type of therapeutic process normally begins with the expression of repressed emotions as they have attached themselves to present people and situations. Before the subject can approach and relive a traumatic memory from early childhood (core experience), he usually has to face and work through many situations from later life that have a similar theme and involve the same basic elements. All these traumatic situations from different life periods are associated with emotions of the same quality and with identical defense mechanisms.92 The displacement of unconscious feelings lays down a pattern of valid experiences throughout one's life which have added more layers to the prototypic trauma itself. These later experiences have to be faced before the earlier trauma can be remembered. In this way, a defense mechanism such as displacement is slowly dismantled as the client goes deeper into his/her unconscious following the pattern of feelings that reflect the displacement. Layers of the feeling's manifestations in the client's adult life are expressed, so that eventually, the prototypic scene is remembered and catharsis reached. The prototypic feelings and memories are the final catalysts for the ultimate realization of how one has acted out the repressed content throughout all of his/her life. Regarding the resolution of cathartic experiences and the associated realizations, Grof states: Once they are known, such experiences help to clarify the patient's symptoms and explain certain seemingly irrational elements in his or her behaviour. The reliving of these events is also accompanied by dramatic changes in the clinical condition. Each of the relived episodes seems to contribute a certain missing link in the psychodynamic understanding of the patient's psychopathological symptoms. The totality of the emerged unconscious material then forms a rather complete gestalt, a more or less satisfying mosaic with a very logical and comprehensive structure.93 Savage made an important correlation when she wondered if she was born with the "insanity" of wanting to die: My insane self rattles through this body, trying to find a way out. But where did my insanity start? Or was I born with it?94 The pain of suicidal feelings, explained as a repressed near-death birth trauma activated into unconscious awareness, predisposed Savage to experience them as her "insane self . . . trying to find a way out". At times

she was close to catharsis as when she describes the upheaval of emotions: I felt I had to sit quietly holding it together, or it would break apart, and all the ugly things in it would spill out all over the floor.95 Her struggle against the suicidal feelings suggests an experience of the pressure of resistance against the uprising of repressed feelings and the actual internal experience of the feelings themselves: On the one hand, I was fighting my suicidal impulses trying to put them down, push them aside. On the other, I felt that my interior was . . . infested with malignancy . . . 96 In her final attempt at suicide which brought her very close to the death experience, Savage felt she had somehow resolved the desire to die. I had to explore the full measure of despair, including the acts of suicide, before I could emerge from it. I had to go the whole dark destructive route living it all the way to the end and ultimately experiencing a kind of death, before I could find the light again and fully realize myself.97 By finally seeing the "light again", a birth metaphor signifying the third stage of birth and the end of the struggle, Savage reached her own resolution. It was the "end" of the birth trauma that she unconsciously strived towards, but in the process she had to re-experience the dying. Savage knew, on a very deep level and without the aid of theory or psychotherapy, that she had to relive dying episodes in order to resolve her suicidal compulsion. Upon reflection she adds that: I did not know it then, but I was making a commitment-an awesome, terrible commitment that involved the pursuit of my own death.98 Clearly, a suicidal act is not a safe way to release impending unconscious feelings. Returning to the near-death trauma of birth in a controlled setting and re-living those memories is the therapeutic condition for final resolution of the suicidal behavior. While this alternative may be obvious to those of us undisturbed by suicidal feelings, the person who is, can only feel the emergent impact of the agony of wanting to die. Stan Grof discusses his observations of clients who have relived their births and the dying stages: When suicidal individuals undergo . . . therapy and complete the death-rebirth process, they see suicide retrospectively as a tragic mistake based on lack of self-understanding. A person who does not know that one can experience liberation from unbearable emotional and physical tension through . . . reconnecting to the state of prenatal existence without suffering any physical damage, might be driven by the catastrophic dimensions of his or her agony to enact an irreversible situation in the material world that involves similar elements.99 Clinical reports of suicidal people re-living a dying experience at birth show that resolution of suicidal behaviour frequently occurs in abreactive/age-regressive therapy: . . . severe suicidal urges disappeared completely when patients worked through and integrated perinatal material . . . no matter how difficult their life situations and circumstances were from an objective point of view, suicide somehow no longer appeared to be a solution.100 SUMMARY The most serious expression of the trauma of birth is in suicidal tendencies and the desire to die. Within the biological process of dying comes a surrender of the body to the forces of death. The deepest part of the self remembers these feelings by experiencing them in the present, but of course, without a conscious connection to their source. The experience of the old feelings weaves its way through the person's life-patterns and behaviour, constantly reminding him/her of what it once was like to experience the sensation of dying, constantly urging feelings of self-defeat and self-destruction. When difficulties in life become overwhelming, and external stresses overload one's ability to cope, the anxiety of the near-death experience is compounded and defense mechanisms taxed. The only way through present life struggles is for the suicidal individual to die. In actuality, this often fatally narrow choice may be a repetition of a birth memory embedded in the unconscious. Regressive therapy, which incorporates abreaction or catharsis, essentially produces a reversal of the present feelings that manifest in self-destructive behaviour. The "now" feelings are taken out of their present context and brought back to the prototypic trauma that caused their repression in the first place. The goal is to isolate the specific early trauma and re-live the emotional sequence. Thus, the need to repeat unconscious material from that trauma is absolved by the catharsis while new life skills and coping strategies are fostered. References REFERENCE NOTES 1. National Task Force on Suicide in Canada (1987) Suicide in Canada: Report of the National Task Force on Suicide in Canada. Ottawa: Ministry of National Health and Welfare. 2. ibid., p. 25. 3. ibid. 4. ibid. 5. ibid. 6. ibid. 7. ibid. 8. Durkheim, E. Suicide: A Study in Sociology. (1951) New York: Free Press. 9. National Task Force on Suicide in

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