The neurology of the unborn foetus is vulnerable to maternal psychological distress, when it is co-incident with the onset of labour. The resulting imprint will serve as a sensitising focus for the development of future neuroses; and can contaminate the outcome of psychotherapy unless identified and reprogrammed.

Hypnotic regression - how far back?

Dr Donald W Ebrahim LRCP MRCS

Donald W. Ebrahim LRCP MRCS, *after thirty years in hospital and family practice, has been a full time private psychotherapist since 1982, by which time he had completed three hundred and fifty hours of training in short-term analytic psychotherapy under the personal supervision of Professor Lewis Wolberg M.D. and Professor Arlene Wolberg Ph.D. of the Postgraduate Centre for Mental Health, University of New York. He lectures internationally and has published several articles on hypnosis and Neuro-Linguistic Programming.*

To be aware of the need to search for traumatic memories in the past as far back as birth, and even before if feasible, is basic to the understanding of psychoneurosis in the present, and its effective management.

Even clients know about this link between past and present. I remember an anxious middle aged man who complained of pain on swallowing - doubly painful because he had gourmet tastes. The symptom appeared three years previously and medical investigations were negative. He was married with no problems, but just before his illness there was some stress - he was rejected for promotion to senior management within his company. This, he said was painfully disappointing, having been with the firm all his working life.

Without batting an eyelid he calmly requested hypnotic regression to confirm a recurring idea that he might have experienced death in a past life by hanging! I congratulated him on such resourceful thinking, but suggested we deal with more recent stress first, like being passed over for promotion, and more distant stresses could take their proper turn later on.

"Stress" I explained, "consists of excessive demands on our energy stores; and we only have three - mental, emotional, and physical. And when our energy stores are depleted we have to borrow energy. Your mental and emotional energy stores were depleted three years ago, and so for three long years you had to borrow energy to think; you had to borrow energy to smile and be friendly; and if you were tired you had to borrow energy to physically go from place A to place B, and the only source of energy for us humans is a chemical called adrenaline; and from your schooldays you can remember that adrenaline prepares us humans for fight and flight - even though there is no real live tiger to fight or run away from in flight".

With ongoing somnambulistic compliance he calmly nodded his head and accepted that autonomic responses of raised serum catecholamines and sympatheticotonia involving muscles generally, lay behind the muscular tension in his throat - "and this muscular tension in your throat stops you from over-eating, and therefore keeps you lighter in weight so that you can run away faster in flight". The change in his expression was instant and dramatic! My interpretation? He was congratulating me on my resourceful thinking!

Penfield (Penfield 1959)[1] while operating on the brain under local anaesthesia, electrically stimulated the temporal lobes with a fine electrode; and the patient, with each such stimulation recalled various past memories. This is the earliest evidence of a neurological location for the unconscious mind or memory bank. Subsequent research suggests that the brain is the "biological equivalent of a hologram" with a "holographic memory down to the finest details" (Restak 1979)[2]

The structure of a subjective experience of awareness comprises all of the five senses and can be coded as VAKOG with visual - pictures

[1] *Penfield, W. and Roberts L. 1959. Speech and Brain Mechanisms Princeton University Press, Princeton. N.J.*

(V), auditory - sounds (A), kinaesthetic - feelings (K), olfactory - smell (O) - and gustatory - taste (G) elements. Research is therefore suggesting that it is stored in such detail in memory, and can be recalled as such. Clinically it appears that any of these sensory stimuli can, like Penfield's electrode, trigger off a past memory. Pictures (V) of old school friends and hearing (A) the old school song take me back to "the happiest days of my life". The fragrance (O) of Eau-de-Cologne reminds me of my mother in her later years, and the taste (G) of bread and-butter pudding brings back childhood joys of gourmet treats.

The kinaesthetic - feeling stimulus (K) however, is a little different. If one is feeling the kinaesthesia of anger or fear, it is usually accompanied by muscular tension. Kinaesthesia as a feeling of joy on the other hand, relaxation, or any other sense of pleasure, is usually unaccompanied by muscular tension. It therefore follows that if one canalises one's attention on muscular tension as a sensory stimulus it should trigger off past memories that did have anger or fear i.e. trauma as it's component.

Here then is the key to understanding hypnotic age regression as the divining rod in the search for past traumatic memories. Canalising attention on muscular tension in the present will serve as a bridge to connect present awareness with the muscular tension (K) in a past traumatic memory - and additionally, even with its visual (V) auditory (A) olfactory (O) and gustatory (G) elements, - VAKOG. Regression to past trauma however can also occur by canalising attention on visual (V) and auditory (A) elements; for example "Let your mind drift back and imagine being small again and seeing (V) your first school. Perhaps you can hear (A) the sound of your teacher's voice, and perhaps you might be able to feel (K) the feelings you had then". In this way a complete memory programme (VAKOG) - traumatic or otherwise - can be recalled.

To ensure survival and inner peace, the brain continuously strives to make sense of reality which includes trauma, through ongoing modelling processes of generalisation, deletion, and distortion. For example, if the red hot bars of an electric fire had inflicted pain on an exploring infant's hand, then the colour red will be generalised as traumatic or painful, and to be avoided. These modelling processes are ongoing neurological mechanisms (Ebrahim 1992)[3] operating from birth onwards, and probably also during foetal life. Cheek (Cheek 1993)[4] has collected interesting clinical evidence which suggests that "telepathy, clairvoyance and some form of hearing are perceptions available to the human foetus from the emotional moment its mother knows she is pregnant, onwards".

A traumatic past experience that can be looked upon as universal, because it occurs to all of us at some time; and with current clinical evidence, probably from foetal life onwards is a physically or emotionally traumatic separation from the mother. The separation can be accompanied by physical trauma as in tissue-damaging experiences at birth or in childhood, or emotionally traumatic – as in emotional distancing, for example if the mother's mind is preoccupied with psychological distress prenatally, which is what this discussion is all about, postnatally, or during the child's early years. As there are no perfect parents or environments, this traumatic separation happens to everybody, but for some the trauma may be more intense than for others.

As there are no perfect parents or environments, traumatic separation happens to everybody, but for some the trauma may be more intense than for others.

Being without logic or reason the foetus, infant or child, generalises and therefore interprets this painful separation emotionally (K) as rejection, and this initiates the basic personality conflict of separation versus attachment, with a need to attach intensely to mother or symbolic representations (generalisations) of her - e.g. home (agoraphobia); food (bulimia); cigarettes, alcohol and other oral comforts (addictions).

The rejection leads to feelings of hostility for feeling rejected and guilt for having the hostile feelings. Rejection also leads to a mistrust of love and a fear of rejection again, with sensitivity to criticism and a need to please; and the basic feeling of inadequacy leads to feelings of fear of failure and perfectionism to overcome the inadequacy. This paradigm (see illustration) of emotions is basic to all of psychoneurosis, and very pertinently is triggered off by separation

2
Restak R.M. 1979. The Brain, the last frontier, New York Warner Books Inc. 252 - 254.

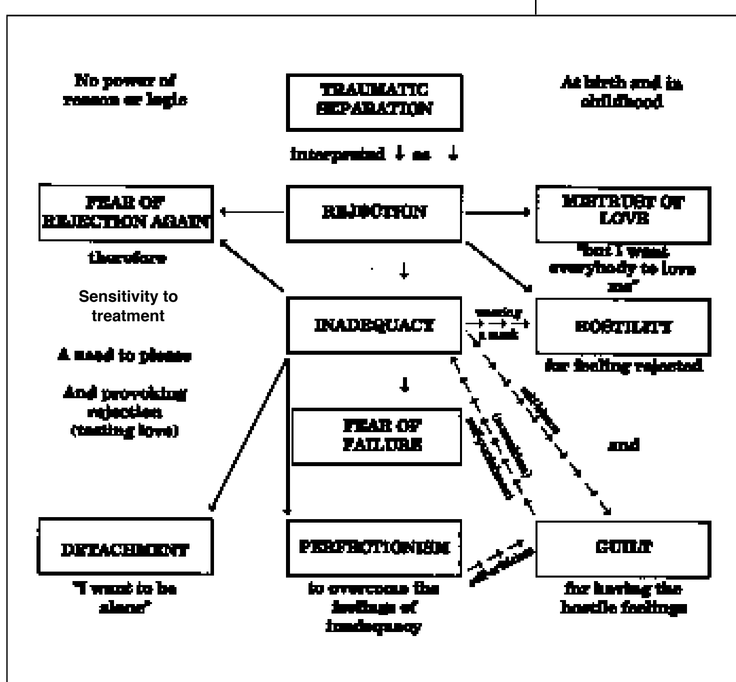
3
Ebrahim, D.W. 1992. Stop doing to yourself what your parents didn't do to you. A new look at Neurosis and Change. Hypnos, Swedish Journal of Hypnosis in Psychotherapy and Psychosomatic Medicine. February Vol XVIV No.1 14 - 25.

4
Cheek, D.B. 1993. On Telepathy Clairvoyance and "Healing" in Utero Hypnos, Swedish Journal of Hypnosis in Psychotherapy and Psychosomatic Medicine and the Journal of European Society of Hypnosis in Psychotherapy and Psychosomatic Medicine. June Vol XX No.2 76 - 84.

from special attachments - traumatic or not - or rejections in childhood and later adult life.

I call it the "psychological separation/rejection wound" which "bleeds" each time separations or rejections occur; and on this basis my criterion for a strong mature personality - at any one moment in time - is the ability to tolerate separations and rejections.

The "wound" can also "bleed" as the result of stress. Stress releases catecholamines that stimulate not only the conscious but also, like Penfield's electrode, the unconscious mind, thereby "switching on" the separation/rejection programme. I often come across this "ongoing pain of separation/rejection" syndrome in students who, after the stress of intense prolonged studying for examinations, develop agoraphobic symptoms with panic attacks; even though they may have passed with flying colours.



With current neurological understandings it is probable that regressions to past life experiences are problem solving, hallucinatory fantasies and symbolisations, i.e. generalisations facilitated by the trance; or bits of information accrued from various sources and subsequently not remembered consciously. On the other hand regression to birth and intra-uterine existence and recall of traumatic memories in these situations are feasible neurologically, and evidenced clinically. Although the foetus and new-born baby have no language at birth, canalising on visual (V) and auditory (A) elements of an imagined birth process in an anonymous woman to begin with, can by generalisation and direct suggestion connect up with the VAKOG of the client's own birth experience.

From the basic premise that all neuroses have muscular tension (K) as a common denominator, search techniques rely on the signal of **extra tension** in some part of the body, whenever contact is made with a relevant past traumatic memory. It is interesting and also significant that the tension contacted in the past is the **same in nature and location as that accompanying the actual adult neurosis.**

The technology of **neuro-linguistic programming** (NLP) makes it possible to reprogram the past traumatic separation/rejection programmes, i.e. to create new programmes based on logic and reason, that deactivate the effects of the traumatic ones.

The purpose of this article is to draw attention to the fact that psychological distress in the mother at the onset of labour can imprint itself in the brain of the unborn foetus. It exists as a programme that is separate - requiring separate management. It is apparent clinically that in some cases, two of which are about to be described, if it is not identified and reprogrammed a neurosis will not resolve completely.

Case History No.1

I was consulted on the 2 July 1987 by a 71 year old woman for panic attacks which occurred whenever she was alone at night. She lived with her bachelor son aged 45, her husband having died suddenly 10 years previously. She was one of seven children and the child preceding her own birth was a girl who died in early infancy.

Her panic attacks started in 1983 when she was abroad and about to board a boat to return to England. She panicked when her son kept her

waiting on the quayside to the last moment - she was afraid she might miss the boat and him, and be left alone with baggage and no accommodation until the next day. The panic consisted of a sensation of pressure in the middle of the chest (R) with the thought (A) “I could die if I am on my own”. It was eased by contact with anybody, even on the phone.

In therapy she was regressed to the original sensitising experience and a number of past relevant traumatic experiences throughout her 71 years! Reprogramming was only partially effective. At the end of 1987 she developed psychosomatic symptoms in the large bowel. She was seen once during 1988, and communicated with me by phone on 2 subsequent occasions in that year to calm her feelings.

On 26 April 1989 she requested further therapy. I decided to repeat the reprogramming of her birth trauma which was positive in 1987; but this time the search was deliberately directed towards identifying a possible traumatic memory resulting from psychological distress in her mother before the actual birth. This search was positive. As she imagined her mother’s face, projected onto a TV screen showing the pain of separation from her pregnancy with my client, I specifically asked her whether she was aware of any **extra tension in her own body at that moment in tim**e. She clutched her chest and said “Yes its here”.

I then asked her if there was any reason for her mother to be worried at the commencement of the labour pains. She replied that her mother had told her when she was older how very frightened she was for my client’s well being, worried that she may also die like the previous child, in early infancy. The traumatic imprint was reprogrammed using NLP technology as will be described later.

Three months afterwards she had no recurrence of her panic at night, and on 26 July 1993 I telephoned but spoke to her son because she was on holiday in America. He told me that she was alright and able to cope with being alone at night.

Case History No.2

On 20 November 1981 a 35 year old woman who was adopted at birth consulted me with intermittent agoraphobia following her adoptive father’s death when she was 22 years old. Like the previous case her neurosis was never completely resolved after therapy; always remaining as low-grade free floating anxiety with intermittent panic attacks and agoraphobia - her husband having to stay at home with her from time to time. She has had a complete life scan, and regression to birth which was positive to trauma; and all relevant past traumas had been reprogrammed.

On 14 July 1993 she came with yet another relapse and this time I regressed her to the period immediately before birth and she was able to identify the same chest pain that accompanied her panic attacks, when she imagined the anxious face of her biological mother at the commencement of the birth sequence imagery. She had been told that as she was illegitimate the decision to have her adopted was made before she was born. After the reprogramming of this traumatic imprint she felt dramatically improved, and a week later was extending her separation distances from home far more than she had ever thought possible.

Situations found to be responsible for maternal psychological distress so far, are:- marriage out of wedlock; the baby having to be adopted; a previous pregnancy ending in still birth or death in early infancy; death of somebody close shortly before the birth; grave post-natal complications with a previous pregnancy, wanting a male child for the first born; desperately wanting a child of a certain sex for various reasons.

The Technique

Abreactions could be severe so relaxation and ego strengthening is helpful at the beginning.

Also, a double dissociation with protective anchors is established to limit abreaction.

The technique involves a recognition that throughout the hypnotic work there should be communication between the left hemisphere of logic and reason, and the right hemisphere of imagery feelings and memory so that re-education and catharsis respectively are involved in ongoing processes of change, which can occur at meaningful levels of awareness.

Verbalisation is therefore very important, to define, and therefore structure these phases of hypnosis. For example:-

‘...As I count from 1 - 10... the other parts of your mind might be able to imagine yourself going through ten stages of progress to a level of inner comfort where communication between the parts of your mind can become so complete in the light of their separation...

And as it is the right and the duty of your unconscious mind to help you…so your unconscious mind can now let a feeling of increased concentration become part of your total mind...and you can talk to me in this state of increased concentration...and you can remain in this state of increased concentration….increased concentration on thoughts…feelings…and memories that are relevant to our work together...'

After ego-strengthening suggestions and the establishing of a double dissociation with protective anchors to limit abreation, the following verbalisation takes place:-

'…Now imagine a TV screen…Move the TV screen further into the distance so that you can just identify clearly whatever appears on the screen…Nod your head after you have done this...

Now imagine an anonymous woman giving birth to an anonymous baby...Imagine ***a look of pain on her face as she begins the pain of separation*** *from her pregnancy with her child...Nod your head after you have done this...*

Now imagine the baby being born…Hear the infant's cries...

Now imagine a pair of hands cutting the cord…separating that baby finally and completely from the mother...

Now imagine a pair of hands picking that baby up and giving it to the mother...See a look of joy on the mother's face…hear the baby' s cries getting quiet...See the quiet contented baby being bonded to its mother's bosom in a fond embrace...

The pain of separation is over for both of them...There is only love...strength and comfort that they share together...

The pain of separation is the price both mother and child had to pay for the privilege of having had the attachment… ***but that price was never meant to be paid over and over again****...It had to be paid but once paid...* ***it then purchases the true legacy*** *of the separation experience which is the* ***love, strength and comfort*** *that each got from the attachment...*

Now imagine your ***mother's face*** *on the shoulders of that anonymous woman...* ***Imagine a look of pain on your mother's face…She is beginning the pain of separation from her pregnancy with you...And as you imagine the look of pain on your mother's face tell me where you might be feeling extra tension in your body now."***

At this point if there is no extra tension experienced by the patient I then say:

'...Imagine that a part of you can float across the room into that image of your mother's body...Nod your head when you have done this...

'...Now imagine that that part of you can feel the pain of separation that she is feeling...and as that part of you feels the pain of separation that she is feeling…tell me where you are feeling extra tension in your body now...'

If no extra tension is felt; one can conclude that there was probably no emotional trauma in the mother.

Reprogramming

If **extra tension was felt,** then reprogramming of this traumatic imprint should take place before the rest of the birth sequence is explored for possible traumatic episodes that need to be reprogrammed, e.g. when the foetus leaves the womb; when it enters the narrow birth canal; at the moment of birth; when the cord is cut; and during bonding where separation into an incubator or intensive care may have occurred.

'...You now know that before you were born...as your mother began the pain of separation from her pregnancy with you...she was experiencing some anxiety sufficiently strong to communicate itself to you before you were born... ***confirmed by extra tension that you feel in your body now****…Using your present understandings you can tell me what could have been worrying your mother… making her feel anxious before you were born...'*

The client may have provided the necessary information earlier and confirm it, or say that no information is available.

'...Now imagine you can communicate with her through me...

Pre-natal transference

*First of all thank her...say to her in your head not out loud...**Thank you for going through those feelings** of emotional pain for me out there because it has helped me to make contact with the very origin of my nervousness that I have had for so many years* (or whatever period of time applies). *That makes sense to you...does'nt it?...' - patient nods.*

*'...Now make her feel an **adequate** human being because we both like her and respect her...Say to her **it was normal for you** to feel so anxious about the outcome of the pregnancy...*

And various reasons could be given depending on what information was available; for example a previous still birth or a first baby in an elderly mother. But if nothing is known, general terms can be used; for instance:
*'...whatever it was that was making you anxious about the outcome...**was normal for you**...Having babies are important events and it is normal for you to worry about things not going properly...Your brain was doing its best for you at that time...*

You thanked that image of your mother and you made her feel an adequate human being...

*Now say to her...I am from your time future...I am the baby you are carrying and because I know all went well...we survived and I lived to adulthood...and because I know these things that you didn't know then...**I will protect you from those feelings of anxiousness**...I will protect you from those thoughts...fears and tensions...I will protect you because I am strong and wise...'*

And perhaps some specific suggestions like;

'...I am that baby you are carrying...and were frightened of having adopted...But I had wonderful adoptive parents who gave me lots of love... **- or -** *through the strength I got from you...I survived many hardships...'*

*You **thanked** that image of your mother and you made her feel **adequate** and you have **comforted** her through me... Is there any thing more you would like to say to her to comfort her even more?...Then say it now...'*

Usually the client says: "I love you".

'...And now is that image of your mother looking calmer and happier because of what has been communicated... If the answer is - **NO** - then say: *...then there is something more you have got to say to her...'*

Usually this is due to feelings of guilt - ashamed for feeling inadequate and frightened, and ashamed for getting pregnant out of wedlock for example. Usually the client agrees when this is explained.

*'...So say to her...**I will protect you from any guilt** that you may have...**because you did nothing wrong**... It is **just a psychological reaction**...and you have suffered enough anyway...And now is she calmer and happier because of what has been communicated to her?...'*

The client usually agrees.

'...Then imagine that image of your mother is floating towards you now where she belongs...and imagine you are gently squeezing her into yourself where she belongs...and feel the energy of her adrenaline that she brings with her...that's right...

Now switch on a new TV screen and once again see your mother's face full of the pain of separation from her pregnancy with you...And as you see your mother's face full of pain, tell me if there is still extra tension in your body or has it now gone...'

The client usually says that the tension is gone.

*'...Then imagine a happy and calm mother again...and once again...imagine that the happy calm image of your mother is floating towards you where she belongs...and once again gently squeeze her into yourself where she belongs...and feel the **love... strength and comfort** that she brings with her...'*

The reprogramming will now be complete.

After this has been done any other traumatic episodes in the rest of the birth sequence should be reprogrammed.