

“Derepression and Reprocessing”: Food for Thought from a Patient

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Abstract: Derepression and Reprocessing (D&R) is a developmentally transforming therapeutic process with the specific aim to resolve physical, emotional, psychological, and philosophical conflicts stemming from pre- and perinatal trauma(s). A new life undergoing pre- and perinatal traumas due to materialistic birthing practices often suffers from stagnation on various levels. Mental and emotional stagnation are carried forward into adulthood possibly resulting in intellectual and ideological fundamentalism and fanaticism or a black and white infantile mentality underscored by the materialistic philosophy of “might is right”.

The internally driven process of D&R moves in layers from the least to the most painful and from the before, after, and during (core) aspects of a particular trauma. During derepression, the evidence of the body, senses, emotions, infantile behaviors, and thoughts brings recognition which leads to verbalization and knowledge of previously repressed pre- and perinatal memories. During reprocessing the splintered self is gradually reintegrated into a whole human being without conflicts between body and mind, feelings and actions, canceling out all psychosomatic manifestations.

Questions are raised about the effects of pre- and perinatal trauma(s) upon the neural, chemical, and electrical systems of the brain, about organic memory, and such phenomenon as impulsivity.

Zusammenfassung: „*Aufhebung von Verdrängung und Wiederdurcharbeitung*“: *Bedenkenswert Anregungen von einem Patienten.* Aufhebung von Verdrängungen und Wiederdurcharbeiten sind transformierende therapeutische Entwicklungsprozesse mit dem spezifischen Ziel, körperliche, gefühlsmäßige, psychologische und philosophische Konflikte aus vorgeburtlichen und geburtlichen Traumata aufzulösen. Mechanische Geburtspraktiken können zu vorgeburtlichen und geburtlichen Verletzungen führen, die Entwicklungsstörungen auf verschiedenen Ebenen zur Folge haben können. Geistige und gefühlsmäßige Blockierungen werden ins Erwachsenenalter mitgenommen. Dies kann eine Neigung zu fundamentalistischen und fanatischen Einstellungen oder einem kindlichen Schwarz-Weiß-Denken führen, dem eine materialistische Philosophie „Macht ist recht“ zugrunde liegt.

Der seiner inneren Dynamik folgende Prozeß der Aufhebung von Verdrängungen und deren Wiederdurcharbeitung bewegt sich in Schichten von weniger Schmerzhaftem

zu mehr Schmerzhaftem und von der Zeit vor, während oder nach zentralen Aspekten eines besonderen Traumas. Während der Aufhebung der Verdrängung ermöglicht die Evidenz von Körpergefühlen, Empfindungen, Gefühlen, kindlichen Verhaltensweisen und Gedanken eine Einsicht, die zur Verbalisierung führt und einem Wissen um vorher verdrängte vorgeburtliche und geburtliche Erinnerungen. Während des Prozesses des Wiederdurcharbeitens kommt es im gespaltenen Selbst allmählich zur Reintegration, zu einem vollständigen Menschen ohne Konflikten zwischen Körper und Geist, Gefühl und Handlung, und einem Aufhören der psychosomatischen Reaktionen.

Die Wirkungen von vorgeburtlichen und geburtlichen Traumata auf nervale, chemische und elektrische Systeme des Gehirns werden diskutiert, wie ebenso das Vorhandensein eines organischen Gedächtnisses und das Wesen von Impulsivität.

Introduction

Today, many new types of therapies have come to the fore from retrieval of birth memories to its antithesis *The Culture of Prozac* and Ritalin for children (Chamberlain 1980, 1988, 1990, 1992, 1995; Janov 1983; Miller 1983, 1990; Frederickson 1992; Terr 1994; Cowley 1994; Adler 1994; Begley 1994; English 1995; Verny 1995; Hancock 1996a,b; Ingalls 1995)

Back in 1970 when I began to consult a psychiatrist, psychology and psychotherapy were responding to changes that were underfoot. *The Primal Scream* (Janov 1970) had just been published. In 1971, the International Society of Pre- and Perinatal Psychology and Medicine was founded in Vienna, Austria. Leboyer's *Birth Without Violence* came to the United States in 1975. Behaviorism was just beginning "to be supplanted by cognitivism" (Hunt 1993) and insight therapies (Beck 1976). Notwithstanding Otto Rank's theory of birth being universally traumatic, for me to be confronted with actual memories of birth traumas was an anomaly and the entrance into a territory to be pioneered.

Beset by what is currently termed dissociative-repressive amnesia (Terr 1994), conventional cognitive therapy had made few inroads with me after two years of hard work. Resistance toward emotional expression and insight was fierce. One day, my psychiatrist realized that it was nearly impossible to break down my defenses as long as I remained seated in a chair. He asked me to lie down on the floor. The moment I was prone, I felt myself going utterly blank. While my mind *went away*, my body and senses took over. With one part of my brain observing, I felt myself swaying through the air. I felt my body colliding with gusts of cold air. The frigid swirls literally brought goose pimples to my flesh. I had the distinct sensation of being swung in an arc till I felt to be upside down. I was shivering uncontrollably until everything went internally completely still and limp. This sensory re-experience of what I call the Upside-Down trauma was the beginning of my journey to as far back as the sixth month in utero with the help of 'Derepression and Reprocessing' or D&R.

Materials and Methods

I shall not be so presumptuous as to claim a new type of therapy, especially as D&R has been virtually a 'one-man show' or a private journey lasting over twenty-five years. Rather, it has a particular focus which developed by trial and error and

grew out of need for unconventional means. In the final analysis, “Derepression and Reprocessing” is a philosophy oriented therapy and operates on the premise of the *primacy of syntax* (Bickerton 1995).

At the source of all negative and defensive behavior lie philosophical conflicts – conflicts between unconscious and consciously held beliefs and between one’s personal and cultural ideologies. For instance, youths belonging to city gangs subordinate their individualism and independence to the leader and majority of the group to which they belong. Seeking safety in numbers, the group as a whole defies cultural ethical norms. Their philosophy of ‘might is right’, which recognizes no laws, is underscored by the use of weapons and often brutal force to enhance their pseudo-self-esteem. Poverty notwithstanding, these youth of the city streets live essentially in philosophical quicksand.

The primacy of syntax in the therapeutical setting was essential for the resolve of all my unconscious conflicts and indispensable concerning repressed traumatic experiences dating back to my fetal days. Pre- and perinatal traumatic experiences in particular have no linguistic representations in either the unconscious or conscious mind. For me, successful therapy was dependent on the translation of the physical, sensory, emotional, and psychological aspects of my pre-verbal traumas into percepts and later into concepts. Memory recovery per se was **not** sufficient. Reliving traumatic experiences and expressing the concomitant emotions was the first step in this three-tier process. Our *emotions are estimates of that which furthers or threatens our values* (Rand 1964). Upon reliving and expression, experiences and emotions need to be verbalized and given linguistic contents. Subsequently, the values underlying the emotions have to be identified with precision, reevaluated, and integrated into a conscious system of ethics. This integration will establish a sound knowledge of identity.

The argument that the human mind in its development from pre-nate to pre-verbal toddler is incapable of coming to conclusions and developing a primal philosophical value system is no longer tenable, (Janov 1983; Ingalls 1995; Verny 1995). A pre-/neonate’s first experiences are encoded by means of the pain/pleasure mechanism, emotions, reflexes, and response behaviors. The negative impact and the intensity of traumatic experiences leave deep imprints and are, therefore, memorable in mind, body, and neurons especially those in the limbic system. I also believe that pre- and perinatal traumas affect, if not upset, the balance of the neurochemistry within the brain and body. These imbalances are often thought of as genetic and hereditary. A few examples: my own memory retrieval (Ingalls 1995) led me to re-experience infantile rage. In therapy, verbal anger invariably changed spontaneously into infantile behavior of flailing arms and thrashing legs ending in a spastically arching back with head thrown back in the fashion of the Moro reflex. In hindsight, throughout my life, whenever provoked into rage, the manner of expression had virtually been identical to the ways it was expressed in early infancy. Thus, this initial reflex became a learned behavior with the underlying premise of “kill or be killed,” which belongs to the philosophy of ‘might is right’. Thus, such early imprints led to a behavioral pattern and a primal philosophical leaning. Similarly, when deep into my birth traumas, intense baby wailing would occur containing an array of emotions from irritation to hate to grief. Depending on the specific traumas I was working on, I was overcome by sudden

water diarrhea or would nearly pass out. Such behaviors and physical reactions did not cease until therapy was completed and the philosophical ideas underlying the rage, other emotions, and behaviors had been identified and altered. To wit: infantile wailing and screaming are perceived by experts as undifferentiated. In my experience, the wails were predominantly emotional expressions while infantile screams were closer to psychological responses. Death screams in particular contained raw horror and terror, fear of death, active protest, fury at the injustice, pleas for help to make the abuse stop, a desperate reach for survival, and, last but not least, the crushing realization that you are powerless as an infant against force – the force inherent in materialistic birthing practices. In the therapeutical process, these differentiations came to light together with their unique effects on my psyche and unconscious primal philosophy.

Though pre- and perinatal traumas own no verbal constructs in the mind, there are four other sides to the human being on which therapy can draw to recover a repressed preverbal history: the physical, emotional, psychological, and mental (conscious and unconscious) aspects of a person. In retrieving my own experiential history, D&R would invariably bring me first in touch with the physical and sensory aspects of a particular trauma, such as described in the introduction. Subsequently, the emotional side of the experience would emerge. Other sessions would take me down to the psychological level and finally to the mental stratum allowing insights into the philosophical underpinnings. Any session that brought resolve of a particular problem would be on all four levels simultaneously integrating and re-storing in memory the trauma as a total experience. D&R, therefore, is a form of a meta-therapy. It allowed me to reintegrate my splintered self into a whole human being without conflicts between mind and body, feelings and actions, canceling out all psychosomatic manifestations. The term ‘reintegration’ applies to both the resolve of mental and neural conflicts. By the latter I mean, that the need for chemical and neural blocking agents to maintain, for instance, repression and sensory numbness became obsolete. As a result, on the one hand inhibited neural pathways became unrestricted. On the other hand, new encoding took place as pre- and perinatal traumas were relived and felt, verbalized and conceptualized. Thus my mind and brain literally opened up and expanded in a variety of ways.

In my case, there was initially very little to work with. I sought psychotherapy because I could not remember the first sixteen years of my life due to five traumas surrounding my birth and others at ages two, eight, and sixteen, (Ingalls 1995). I discovered that my mental focus was always turned outward. I had hardly any self knowledge. Once I had been taught how to monitor myself, how to look inward and observe sensations, feelings, and emotions, the keeping of a journal became mandatory. This diary developed into a clinical record of psycho-somatic symptoms, physical abnormalities, and patterns, such as of sleep, dreams, eating habits, bowel movements, conflicting behaviors and thoughts, and most importantly transcriptions of tape-recorded sessions. As a pathological repressor, I had neither recall of the most recent events and experiences, nor of materials read or even studied. I began to tape my sessions to enhance my memory. Transcribing and rereading them turned out to be tools to break down resistance, bringing other

memories and associations to mind in successive sessions. Such reviews were also helpful to maintain perspective and confirm progress.

Every four months or so, I reread the previous daily entries. Over time, I discovered that D&R worked in distinct patterns and according to specific paradigms. Foremost among them, is the premise that the unconscious retains every detail of each trauma including the nature of the primal philosophical conflicts. The notion that it is all in the mind is partially true. Though my mind and reason had to process all the data from my repressed history, the knowledge itself was imbedded in my unconscious mind, as well as in the neurons, cells, muscles, and tissues of my being. The evidence of my body, senses, emotions, and infantile behaviors brought recognition which led to verbalization and knowledge of previously repressed pre- and perinatal memories. When my pre- and perinatal memories began to surface they were not integrated by means of language and reason yet, but they were very precise and numerous in detail in the various dimensions. In time, I discovered that I also had the answers to questions and solutions to philosophical conflicts. My main problem was derepressing my entire history. I had to face up to the moral rage and the painful questions about its counter part: guilt by omission and commission. Since emotions are automatic effects, what were their causes?

Once I discovered for myself the therapeutic principle of: *Where there is an accusation there is a confession to be made*. I had turned a vital corner. From long experience, I can safely say that there is no greater danger in therapy than falling prey to the culture of crying victim and entitlement. I had to transcend that phase. My own culpability – blame I had accepted out of necessity – was the major hurdle. Guilt for having repressed and internalized – acts only the self can commit – had to be faced and resolved. Early in therapy my therapist advised me that my guilt was an unearned one and should not carry any moral weight. Good and necessary advice to be remembered but it didn't absolve me from having to work through the guilt. My burden of liability went back to a multiple of birth traumas. Not until I reached the insight that I felt guilty for having survived those traumas could I overcome the conflict between my instinctual need for survival at all cost and the notion that I should have died – should have died for the burden of life was unbearable. Since those pre- and perinatal traumas, I had been unfit to live it. This philosophical conflict was implemented soon after birth by means of behavior in the form of apathy. Let me reflect on the concept of apathy, or more precisely, let me focus on a newborn being forced to resort to apathy after its moral indignation had proven to be impotent. Physically, psychologically, and mentally, the baby resigns from life, society, and itself because emotionally it feels worthless, unfit, rejected, punished by trauma, and hateful towards life and itself. Apathy is actively seeking a state of being soul dead. Thus implicitly, philosophically this infant prefers death over life. This newborn, as yet incapable to commit suicide, carries forward into the future a predisposition toward suicide as a means out of life's problems which notably become overwhelming in the teenage years. When I was in my late teens, I came very close to taking my life. Had my father not committed suicide when I was nearly 16 years old, I may well have succumbed. In therapy I unearthed my deeper motivations for suicide. On the one hand, I was impelled by rage and revenge. My rage was directed at myself for my inadequacies.

Revenge because I wanted ‘them’ to suffer. On the other hand, if I could not get the needed attention in life, at least I’ll get it in death.

In support of the idea that I owned unconsciously all the data and information, I was there when the traumas took place; my brain, body, senses, and mind experienced them. The stimuli from outside were imprinted. Furthermore, my reflexes, responses and emotions were driven by internal mechanisms. Thus, the internal stimuli were impressed. These imprints of external and internal stimuli formed the foundation on which my personal history was build. Future experiences were judged and responded to on basis of my pre- and perinatal experiences. As a result, they became the pith of my historical tree (see Fig. 1).

Also, I was fortunate enough to have had a psychiatrist who understood this. He emphasized the idea that my own recognition and judgments could be the only and final arbiter. “As a therapist,” he pointed out, *I can only make educated guesses about what happened to you, what you did with your experiences, and how you evaluated them knowingly or unknowingly. To aid you in derepressing, my cues have to come from you and whatever is near the surface within you.* The key part of his approach was: “How I had evaluated my traumatic birth experiences.” The pivotal question was: When, why, and how did I contribute, regardless of necessity, whether in the name of survival or not, to my own pathology of dissociative-repressive amnesia?

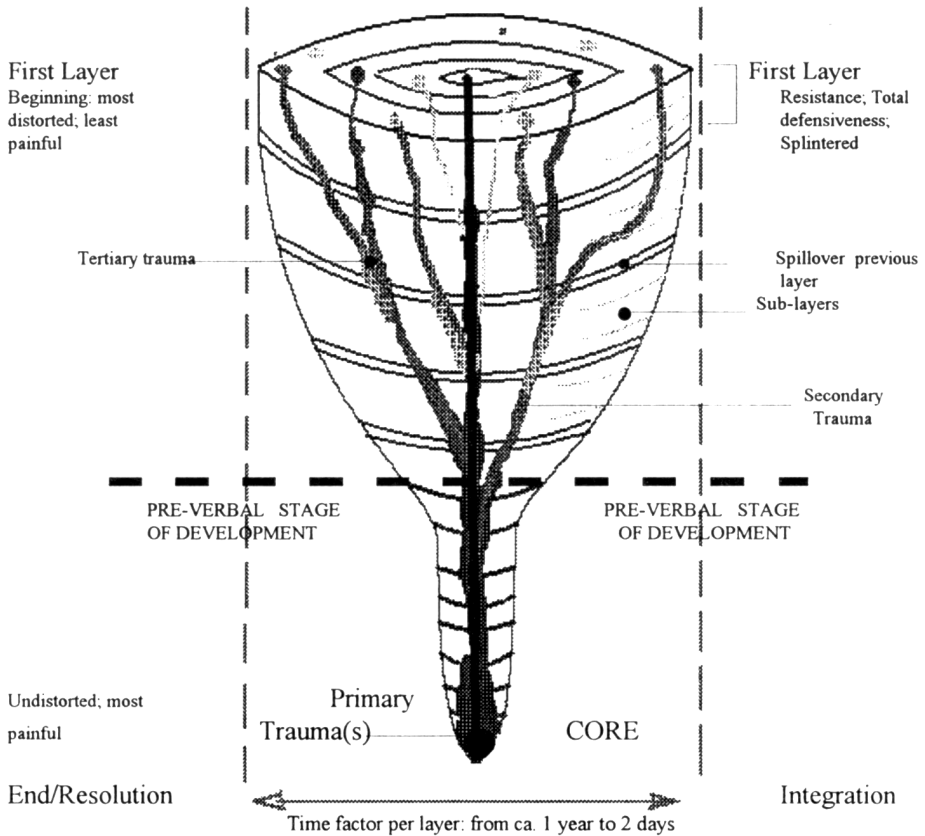


Fig. 1. Graphical representation of derepression and reprocessing (Ingalls 1982)

Unfortunately, there was only one answer: I had to go through the fire again to cure the burns to revive my silenced soul.

From the clinical records, patterns could be discerned from the psychosomatic symptoms that reappeared at regular intervals and always in conjunction with a particular trauma I was working on. To use a popular phrase: D&R peels like an onion. At the beginning of a new layer, the resistance was the strongest and the psychosomatic symptoms were most numerous and severe; at the end of a layer, I experienced a pronounced sense of well-being.

Another paradigm lies in the movement within each layer: horizontally it moves from the least to the most painful, from minor traumas to major ones. In terms of my mental processes, at the onset of each new layer they were the most distorted, convoluted, and subjective. Denial was fierce. At age fifty and onward, it was not easy to admit that an implied conclusion hung on to since infancy was invalid. With each new recognition, admission, and revealed insight the scale began to tip more toward objectivity, honesty, and truth. Vertically it moved from adolescence back to prenatal times. For instance, in one session a particular emotion often brought me in touch with the various emotionally arrested persons within: the sixteen-, eight-, and two-year old, and further back with the neonate, the just born infant, and lastly the pre-nate. The movement between the arrested persons went in both directions and back again. Of interest may be the fact that the spontaneous syntax and vocabulary were age specific. The language itself was often mixed between Dutch, my mother tongue, or English. Dutch was dominant when resolve of an issue was near and my emotions broke through the barriers of resistance. As said above, within each layer, I was carried through the physical, emotional, psychological, and mental aspects of the repressed experience or a part thereof (see Fig. 2).

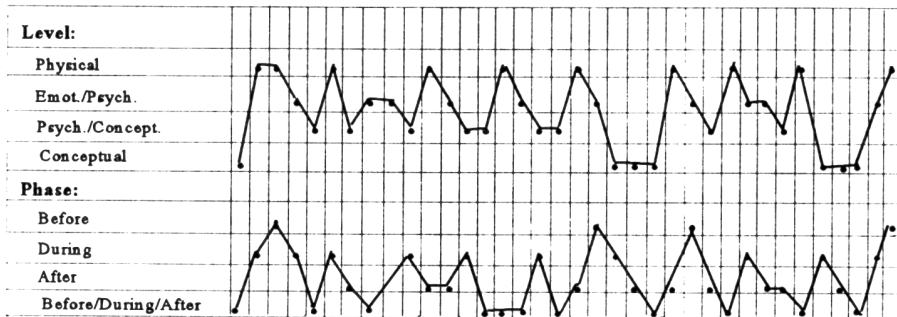


Fig. 2. A graphical representation of patterns near the end of therapy over a 60 day period. Days on which no session took place are excluded. (Ingalls 1995)

Each layer contained one major core issue and often several minor associated ones. The core comprised of the 'during' or most painful aspect of a trauma (see Fig. 3). For example, as a transverse fetus, actual labor pushed me into the canal by the small of my back causing the umbilical cord to be caught in the crease between belly and upper torso. The lack of oxygen was an actual death threat. As D&R advanced me into this re-experience, the death threat was the core or during part of the trauma; the onset of labor the 'before' episode; and, the temporary

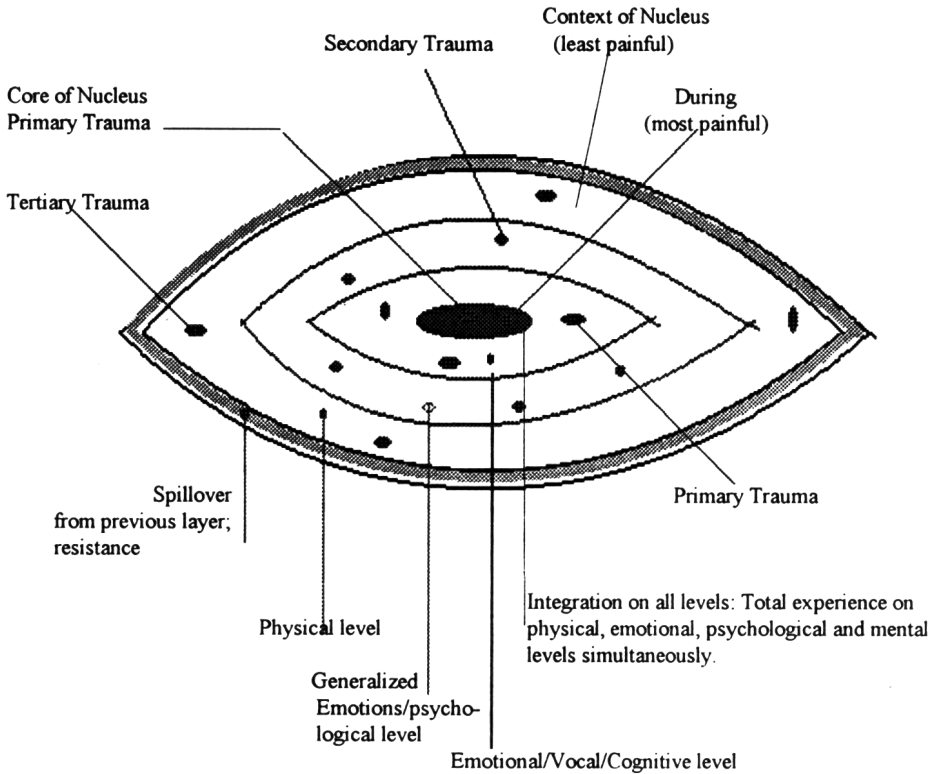


Fig. 3. A typical layer (Ingalls 1982)

cessation of labor through intervention by the attending obstetrician the 'after' period. This division of before, during, and after was distinctive for all traumas I had to deal with regardless at with age they had occurred (see Fig. 2).

D&R required patience and perseverance. Apart from the level of tolerance for pain, the amount of material that could be derepressed in one session was limited. A session lasted between twenty minutes at a minimum and an hour maximum. As the stimulus for derepression came entirely from within, D&R could be called an organic or natural form of therapy. Except for Tylenol™ and laxatives, I never took drugs for fear they might interfere with the process of derepression and upset the neurochemical balances.

I am not a neuroscientist, so I am obliged to use my own words. Apparently, the mind and brain have their own agenda. To borrow Janov's concept of the primal pool of repressed traumatic matter (1971), the mind/brain will release material from this pool that is specific both in contents and amount. The contents is never more severe than the conscious mind is ready to negotiate; the amount is never greater than what can be dealt with in one session. This mechanism has a built-in safety factor to prevent flooding. Flooding occurred when too much material was released to process on a conscious level. This happened occasionally when an unexpected event took place – something unusual yet associatively significant, such as an accident. Another form of flooding can happen at the end of a layer when

resistance is at its lowest. In figure 1 this is termed the spillover between layers. When flooding occurred, the mind/brain shut down temporarily. I learned from experience that forcing the issue beyond what my mind was capable of handling at any given time in the process of derepression was dangerous – another reason why I stayed away from drugs.

Based on the psychological phenomenon of acting out old repressed experiences in a present-day context and on the psychosomatic manifestations, I have always felt that the mind and body are continuously seeking resolve of unconscious conflicts. To me inner pressures, tensions, and somata indicated an inner imbalance and, therefore, the need for a session. The general feelings were of being bloated, particularly in the belly, of being unable to breathe, and a debilitating fatigue. Once into a session with my mind in the observing mode, derepression would begin, it seemed, on its own accord. Via certain brain centers and the spinal cord, tensions would settle in my belly and rise up to the diaphragm area, into my chest, and then up to my throat. Many sessions began with the lowest form of expression: dry crying. Subsequently, a thought, a particular emotion, certain body sensations, or a behavior would activate the process proper. At the end, I felt emptied, more relaxed and free of symptoms. My belly was no longer distended. Not a single session deviated from this format. A few hours afterwards, inner tensions and pressures began to rise slowly again. By the end of the day symptoms reappeared. During the evening, fatigue tended to lower resistance and I became emotionally more fickle which was a receptive state for association. Television dramas and novels triggered emotional upheavals that led to recognition and to memories. Depending on where I was within a layer, sleep and dream patterns were distinct. For instance, I went through a period when I woke up in a transverse position across the bed. In that same period, I was sliding down chutes or narrow passage ways in my dreams or woke up gasping for air. Upon rising in the morning, I was ready for another session. In general, this scheme never varied. I reasoned that within the brain there is an antechamber – a short term storage area for memories that have risen from the unconscious into the pre-conscious. During sleep, their status of being repressed changed to a state of suppression and they could, therefore, be brought into conscious awareness by therapy. As my daily reports showed, this available material was never haphazard. In the early days this was difficult to discern as I was facing sixteen years of repressed matter. In the latter part of therapy, it became clear that each session picked up where the last one had left off. The direction moved from the before to the after to the during period of a trauma and from the least to the most painful. As layer after layer was stripped away, it seemed that a great deal of repetition occurred. This was true. Except, in each layer the degree of intensity became greater while core issues in one layer changed to merely context in the next one. In short, D&R is also a training process. My mind strengthened itself systematically to reprocess increasingly more difficult and painful conflicts.

Of paramount importance was the proper focus. At one point, fear of my own anger was so great, I diverted my attention from it. Rather than becoming angry and taking it from there, I followed a line of thought that was not acute. I tried to force the issue. As a result, I encountered fierce resistance. Somata increased and I became actually sick. D&R required my mind to turn into the unconditional

observer. Random thoughts carried associations. I learned to perceive and focus on the theme rather than on their particulars. Did the theme of the thoughts surround a central emotion? Which and why? Fear? Feel it and be afraid. Go all the way with that feeling and see where it leads. This kind of focus was a veritable “eye opener” from recognition to awareness to verbalization and on to knowledge, i.e., the uncovering of true memories or parts thereof. At certain intervals, there would always be a session in retrospect: a spontaneous telling and reliving of an entire experience from beginning to end in all its details, including the relevant emotions, behaviors, and philosophical premises. The memory would become a continuous whole, especially as in the telling the effects of an experience upon my life were part of it. An example: Until therapy, all my life I ran through time and space as if the devil were on my heels. When I relived in retrospect the Upside-down trauma, particularly the loss of consciousness – to an infant a sensory fall to its death – I finally spat out the words: “It’s not the devil, it is death that has been on my heels. All my life I have been terrified of death. Each new enterprise, each new experience filled me with this heart-racing fear of failure and death.” Subsequently, I was induced to admit: “Ever since I resorted to apathy as an infant, I have been seeking death out of revenge, hate, and spite to make ‘them’ sorry.”

My records of the symptomatology provided interesting insights into how my body and mind remembered traumatic pre- and perinatal experiences in their totality. Those memories were comprised of emotions, reflexes, response behaviors with their inherent notions, and bodily reactions and states. In the present context I am concerned with the last. The Upside down trauma can be used as the most telling example.

As was the custom in Holland in 1941, birth was followed by swinging the neonate upside down, and slap it on the bottom to initiate breathing and to eject the phlegm and lung fluid. Having sustained several traumas before and during birth, I was so depleted, my reserves were nearly drained. Near choking on the fluid, I could not respond. By the time the third slap was administered, I had been upside too long and was near senseless. A moment of suspension followed during which breathing had stopped, every nerve was poised, and each muscle tensed for defensive action. That state of suspension served another function: not to waste any of the precious adrenalin and energy that was still in reserve. Upon the fourth, every nerve, cell, and fiber in my body responded in defense for survival by clenching until collapse. A death scream had risen but was never uttered. Before I lost consciousness, every organ lost control: vomit, lung fluid, water diarrhea, urine streamed out of me. While fully awake and committed to observing only in session, states of utter fatigue, of being nearly senseless, of suspension, and of ‘being unconscious’ were very prominent. Each physical condition had its own identity. Bone marrow deep fatigue left me unable to lift a finger; the main characteristics of ‘being senseless’ was wooziness and having the sensation of reeling; the world and life stood still during that moment of suspension; unconsciousness’ main feat was an awareness of being out of reach and untouchable. On an organic level, I have been overcome by sudden water diarrhea at regular intervals or suffered constipation for days upon which laxatives had no effect. Similarly, instead of being given the opportunity to release all the traumata after I regained consciousness, I was virtually force fed pushing the pent-up emotions further down. All the trau-

mata had lodged in my belly as a ball of pain and tensions. This was traumatic in itself. I refer to it as the Feeding trauma. This trauma affected my mental functions. Sessions leading to release were always preceded by the inability to take in material. I simply could not absorb texts read. Equally, my memory was totally blocked. I could not write, recall, and think. In short, stagnation. I could barely function by rote until a session brought release in the form of intense baby wailing and screaming, often preceded by a violent rage. In real life the need to release had been prevented. I had to repress that need which finally found expression about 50 years after the fact. As a newborn, I was aware of being in a state of stagnation due to unreleased emotions. I believe, therefore, I suffered from colic proper. Today, infants who cry incessantly for hours are diagnosed as having colic which is still accepted as a developmental phase (Chamberlain 1995). In all probability, colicky infants are seeking release from some sort of trauma. I certainly tried to find relief. My very development depended on it.

Association played more than one role. Apart from the common one, at times, when particular feelings were too intense to deal with, my mind would go back on its own to similar, less threatening material and in that fashion introduce me to and prepare me for the more painful memory.

In general, a two-year old is somewhat more able to cope with abuse than an infant is since a newborn has not yet developed any defensive behaviors. Thus a session might begin with emotions and memories belonging to the two-year old within to ease me into similar feelings and awareness belonging to the neonate. A rather striking example began with a dream. At the near end of therapy, I was deeply involved in the Upside-Down trauma and the sensation of falling to my death. My birth experience itself had been resolved and laid to rest for years. In the dream, I was on a small cruise boat on which I was walking around trying to find my way. The ship lay in a small, hideaway harbor. This small cul-de-sac body of water was surrounded by structures. The boat lifted anchor and backed up first before it turned its bow 90° to port to enter an adjoining canal that gave access to the open seas. In the following scene, I was leaning against the bow. Next to me was a crew member – an elderly, tall, and robust man. While watching, I saw a sort of water gate behind which the dark, black water was churning and roiling, much like a caldron or a large active hot spring. Feeling apprehensive, I asked the man what it was. He ignored me. Suddenly, the boat took a nose dive as if sucked into the caldron. I slid forward in a near upside down position. My face and head got soaked and I swallowed water. Somehow, I hung on for dear life and did not fall into the water. The boat straightened itself and headed for the open seas. I thought I understood the symbolism: the upside down experience and falling into that deep well of unconsciousness. For some reason, I drew a picture of the harbor and environment (see Fig. 4). Not grasping what I had pictorialized, from the feelings and description in the ensuing session I realized I had dreamed about birth itself. The ship signified the womb; wandering around the ship meant my finding my way into the birth canal; the backing up and the 90° turn of the vessel is similar to a transverse fetus turning toward the opening of the birth canal. The water gate was the moment I became stuck in the canal, frozen in rigidity when forceps were used. Eventually I was pulled out by hands – the ‘nose dive’ through the birth canal onto final delivery – while choking on lung fluid due to terror and

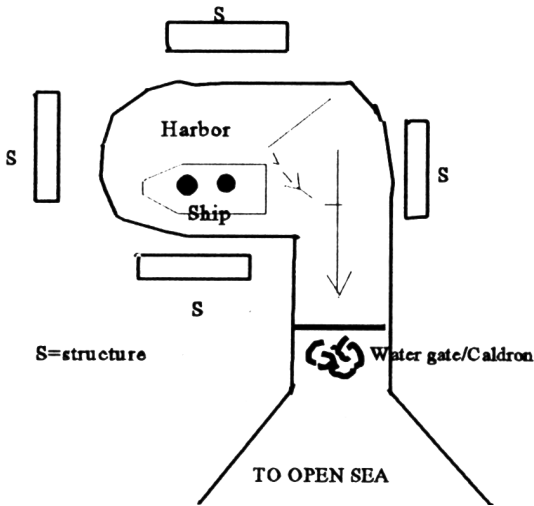


Fig. 4. (Ingalls 1995)

distress. The significance of this dream was the preparation to relive and face up to the core part of the Upside down trauma in the succeeding session: choking and falling to my death or into that deep well of blackness into unconsciousness. Thus, by means of association, a lesser trauma was spontaneously used as an introduction to a similar, albeit more severe trauma. This, too, is an example of how I could have been misled in session by adhering to the analysis that the entire dream represented the Upside-down trauma.

Free association is a tool to be used with discretion. In session, random thoughts often triggered the process of derepression. I learned to let my mind roam freely until a particular thought activated an emotion or behavioral response. These spontaneous reactions from within guided my focus. Interpretation of associations never worked for me. On the contrary, they distracted and caused resistance.

Also, I was always curious as to which experiences and encounters in my daily life carried associations. Refraining from speculation and interpretation, I had learned that sessions could and would reveal them. Afterward, I would say more often than not: "That is why I said such and such yesterday." Or, "No wonder I was angrier than the situation warranted."

In short, daily life experiences triggered relevant associations to repressed memories which were then relegated to the antechamber in the brain during REM sleep. Dreams provided a pre-view of material foremost on my unconscious mind. In turn, a session of derepression brought those memories into the realm of conscious awareness. From there, they could be translated into language, reprocessed, and integrated. Could this possibly be the reverse process of new memories which are temporarily stored in the hippocampus before they are transferred to specific regions of the cerebral cortex (Johnson 1992)?

Dreams, too, were instrumental. In my experience, they functioned as symbolic dress rehearsals for the next session. I can recall a dream in which I wound up running faster than my legs could carry me. In session, I re-experienced being in my crib kicking and scissoring my legs wildly, while wailing urgently, begging for help.

Dreams also served the function of setting the linguistic process of translation of pre- and perinatal experiences in motion. To describe in session the dream scenes and become engaged in the accompanying feelings provided a verbal reality to the sensory and emotional experiences. The most significant part of my dreams were the very images that woke me up. The closer I came to a resolution of a trauma, or part thereof, the more vivid the dreams were. From the dream patterns I learned that at the beginning of a layer when the resistance was at its greatest, I had either no recollection of having dreamed or I had no recall but knew I had dreamed. Occasionally, dreams were so long and complex, a series of sessions were required to grasp the symbolism. Such multifarious dreams are a form of flooding, providing too much symbolic material to process in a single session. Especially in such situations, interpretation is all the more counter productive.

Dream contents began with ideation or thought processes and moved on to symbolism. Initially, the action in dreams was transferred to other people or even animals. In one dream, I was walking down a stone hewed spiral staircase as one might still find in old castles. A little girl, holding my hand, preceded me down the stairs. Suddenly, our hands were wet with perspiration and I felt her hand slipping from mine. I couldn't hold her. I woke up the moment that little girl was about to plunge down the stone steps. In that day's session, I learned that I had defensively switched roles in my dream. The little girl was me and I was the person who held me upside down after birth. Eventually, I myself became the central figure in my dreams. Curiously, when dreams were peopled with men only, physical force was an issue in next session. Women in my dreams constituted psychological abuse. Years ago, when I began to record my dreams, the imagery and symbolism was constantly surrealistic: people were giants, dwarfs, monsters, or creatures from outer space. Scenery and actions were equally out of time. Then a period followed in which people had blank ovals for faces; in the next they were all strangers. Gradually, family members began to appear but in context of the past. In the end, present day characters, friends, acquaintances, and my family of today in ordinary, every day settings occupied my dreams. In this context, dream content can be a barometer of progress and mental growth toward health.

I cannot label D&R as a regressive form of therapy. We cannot regress to our psycho-emotional and mental past when repression in response to pre- and perinatal traumas has led to maturational stagnation. Instead, the realities of pre-speech traumas remain unconsciously active and are carried forward through the developmental stages into adulthood. In my case, I can say I lived and breathed unknowingly my pre- and perinatal traumas on a daily basis and on all levels of my being. As an adult, I had adapted without actually having matured. One example will suffice. An infant's response behaviors and imbedded notions are limited. A pre-/neonate reacts predominantly on basis of the pain/pleasure mechanism and its emotions. A stimulus whether internal or external is either good or bad for it and automatically evaluated as right or wrong. Upon the very first stimulus of pain, pleasure becomes cognitively a value and pain its antithesis. Similarly, in its relations to the external world, the pre-/neonate will develop predispositions and turn pro or con toward certain stimuli and experiences. Thus, in its ideational approach and development, the neonate experiences life and itself in terms of black and white or good and bad. This linear mode of evaluation can develop into

a model for future methods of thought and attitudes toward others, society, and life.

When I was confronted with pre- and perinatal traumas, physical survival called for repression. Since repression is indiscriminate and across the board, I was arrested physically, emotionally, psychologically, and mentally. The consequences for my intellectual development reached far. The implication was an ideational stagnation. In practice later in life, my realities were seen, reflected upon, and judged in terms of black or white, good or bad, right or wrong. Adhering to a code of strict justice, my soul remained blind toward questions of fairness, mitigating circumstances, consideration, and compassion. At the same time, my mind was deaf toward differences of opinion, cultural variances, and ideologies. The rigidity of this black and white mentality was exacerbated because my early traumas were life threatening which confronted me with the imperative of either/or and up or under. There was no middle ground, no room for appeal. In my struggles for survival, I had to win or die. Psychologically and intellectually, the either/or dictate became paradigmatic in the form of combativeness, a tiger-like perseverance, and a mental intolerance and aggressiveness of "I am right and you are wrong," i.e., a fundamentalistic and near fanatic type of intellectual mentality. The underlying premise in its generalized version was: "I have to be right and win because I must survive. To be wrong or to lose is my death warrant."

To emphasize the importance of this issue, a pre-/neonate in the middle of a traumatic experience is always morally right in its protest and feelings of outrage. It is always right using any available means to survive and in its fight against the might of its birth practitioners. Thus, the pre-/neonate **is** right and its caretakers **are** wrong. Such an experience sets the newly born up for a lifelong conflict between itself and the authorities in its life. This is crucial in understanding the minds of fanatics and fundamentalists who have a history of pre- and perinatal traumas. As adults, they can't tolerate being wrong for the unconscious associations carry life threatening charges. As a consequence, they will carry to extremes their belief in being right regardless of the issue in question, particularly when their beliefs are validated by religion or political activism. Too, they cannot be dissuaded from their mandates and fanatic behaviors for they cannot be wrong which underscores their tunnel vision and intolerance. Their philosophy of 'Might is Right' and their self-righteousness is often maintained by brutal force which serves simultaneously as a means to act out their own repressed traumatic pre- and perinatal memories and their unresolved rage. City gang members and skinheads are typical examples.

Therefore, in view of the above, D&R can't be termed a regressive therapy, but rather a developmentally transforming one. Infantile, childhood, and adolescent emotional responses, behaviors, and thought patterns undergo developmental changes and are transformed into healthy adults ones. Subjectivity makes way for objectivity, fostering understanding, sympathy, empathy, tolerance, and other life-serving virtues.

This brings me to some intriguing questions. A stimulus is the catalyst of a neurological or behavioral response. Traumas surrounding birth are by definition bombardments of stimuli to the pre-/neonate. Still without defenses, this new life is wide open, wholly unsuspecting, trusting, and unable to anticipate. In the midst of a traumatic experience, which often escalates into a life or death situation,

the pre-/neonate is so stressed it is not given the time to respond to and process the sheer number of simultaneous stimuli. The neural, chemical, and electrical systems are overloaded. They cannot execute them. Yet, various neural centers of the brain have been fired upon and activated by stimuli. If stress breaks the level of tolerance and if life hangs in the balance, I believe that repressive and inhibiting chemical agents kick in to preserve the various systems from literally blowing up. I believe these inhibitors become deterministic in the development of the traumatized infant. As in my case, my pre- and perinatal history contained three death threats, which, in my opinion, created a neural-chemical imbalance in which inhibitors became dominant. To mention a few examples: repression, the mental blocks against incoming and outgoing data. Once into therapy and at certain intervals, the same symptoms occurred, such as: sudden one-time occurrences of water diarrhea, inexplicable and severe ear aches, penicillin resistant sinus infections, rashes diagnosed as benign German measles, and, intolerable intestinal cramps. All were without medical causes. In each instance, I consulted a physician. Well into therapy, I could not experience an orgasm because the moment sensations reached a certain level of intensity, my body closed down as if a sudden switch was pulled. My body turned dead. Much later, sexual stimulation would flood me with pre- and perinatal memories or trigger intense baby wailing, leaving me in a deep sweat and with a heart galloping at an alarming rate. Ten years into therapy, I developed an arrhythmia for which I had to be hospitalized much later right around the time I had reached the deepest level of the Upside down trauma in therapy, i.e., the moment of losing consciousness. Coincidence or organic memory? Thus, I could suggest that resistance in psychotherapy is not exclusively mental, emotional, and psychological, but neurochemical and physiological as well. Also, I believe that the activated neurons during traumas at birth remained like life wires seeking completion of initiated but unexecuted impulses and responses. These 'life wires' or impulses were held in check by chemical inhibitors and tensions though at times were challenged by associations giving rise to the phenomena of acting out and impulsivity. Some examples. I recall how once my therapist yanked me by my feet into an upside down position. There was absolutely no response, except my mind turned utterly blank. At that time, such handling was far too premature. It wasn't on the agenda of derepression yet. I wasn't ready for it. Thus the association was automatically blocked in my brain. Then the death scream was instigated in real life but never uttered until fifty-four years later. Nearing resolve of the Upside-Down trauma, I experienced severe cramps in the soles of my feet coinciding with physical anger in the form of my legs lashing out wildly and in unison. I realized that the cramps were due to the Babinski reflexes which were initiated but prevented from execution because I was held upside down by my feet. Is there a connection between the above and people committing the most irrational acts on sudden impulses? Another question. IF pre- and perinatal traumas do create neural, chemical, and electrical imbalances in the brain, can such imbalances be passed on to succeeding generations? As the title of this paper indicates, all this provides food for thought.

On a more practical level, my psychiatrist was unconventional to my everlasting benefit. He didn't hesitate to touch me or hold me like an infant which was so provocative, it would bring me immediately into pre- and perinatal experiences.

After four years of meeting bi-weekly, my therapist told me that I was ready to continue therapy on my own. I resisted, but by that time, we had learned the beneficial properties of bath tub sessions.

I happened upon this technique by watching the movie: "The Nun's Story," (1959), with Audrey Hepburn and Peter Finch. In one scene, we watch Ms. Hepburn as nun and nurse supervise mental patients undergoing hydro treatment. For a given period, these patients were locked in hot tubs with only their screaming faces free and visible. Afterward, they returned to their wards quiet as lambs. A basically excellent method but misunderstood in the 1940s. Hot water relaxes the muscles and conducts the release of tensions. Tension is a blocking agent for unwelcome emotions, feelings, sensations, and thoughts. I wondered, what if those mental patients were given the opportunity to talk and be listened to? What would their tortured minds reveal? Actually, out of desperation, I tested my own question. Since, it became my *modus operandi* with the cooperation of my psychiatrist. For me, sessions conducted in a bath tub filled with hot water provided a safe place – much like the womb, the only safe place I had ever known. To be prone on the floor made me feel too exposed and vulnerable which induced resistance rather than relaxation. As the hot water facilitated ease of tensions, no energy was wasted on techniques such a deep breathing, calming of nerves and anxieties. Instead I could focus on becoming the observer and follow inner state of affairs. Furthermore, after a session I could return to my normal daily activities and conduct my life as usual. With virtually daily bath tub sessions, I was able to become productive and more accomplished. My life, so tortured and burdensome before therapy, has changed into one I embrace and am happy in.

Discussion

D&R has certain advantages and disadvantages. On the positive side, whatever has been derepressed AND reprocessed is resolved permanently. At the end of each layer, D&R can be stopped for any length of time without relapse, provided one understands that therapy has not been completed. After a necessary period of undergoing D&R under qualified supervision, D&R can be conducted independently at no cost but time, patience, and perseverance. Sessions can be scheduled when work, family, and other priorities allow for them. As D&R is an active process directed from within, the acquired understanding, self-knowledge, and growth is developmentally transforming. Recently, I experienced that wonderful sensation of actually belonging on this earth and in our society as a native and productive member. I felt no fear, no antagonism toward strangers. The rewards of successful therapy are numerous. I own my own mind. I can think before I act. I can remember and concentrate. The past holds no pain or unpleasant memories. They have been dealt with. I am no longer afraid of tomorrow because of yesterday. I have an identity because my life has continuity from pre-birth to the present. I have earned my independence in the true sense of the word.

On the down side, D&R is not without danger. In sessions, it is easy to imagine or interpret what is near the surface rather than letting emotions, feelings, and thoughts rise from within. To be a true observer of one's inner states is an acquired skill. To stray in focus is tantamount to getting stuck in a groove which will

produce severe psychosomatic side effects. Not to transcend the phase of crying victim causes stagnation. To conduct D&R independently prolongs the process considerably as all the answers have to be searched for from within. To be self-motivated to face up to pre- and perinatal injuries is not an easy task as it requires brutal self-honesty and discipline. Discussion and exchange of ideas with an objective therapist can ease the burden of a difficult and often long process. Ideally, the therapist should be one who supports and follows a patients' leads. As to how long such a process will take cannot be predicted. It is case specific. The problem of repression is that one neither knows how much has been repressed, nor how intense the traumas were, nor how many traumas are involved. However, Janov's concept of the primal pool of traumata (1971), to which I subscribe, means that the process has a definite end. Due to its severity, my case is not one to measure this factor by. Though I believe in the philosophical efficacy and curative powers of D&R, it is not necessarily for everyone. For some the disadvantages may outweigh the advantages. This paper, therefore, is presented as food for thought, to share my insights and understanding of traumatic pre- and perinatal experiences and their effects on the mind and life.

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