O Trauma do Nascimento e sua Relação com a Doença Mental, Suicídio e Êxtase

by Stanislav Grof, M.D.

In one sense this article could be considered somewhat dated since it concerns LSD psychotherapy, a methodology which has not been used clinically for over a quarter of a century. Yet, it continues to be timely since the unconscious realms reached by Dr. Grof's holotropic breathwork are identical with those accessed with LSD.

When LSD was declared illegal in the 1960s, Stan Grof and his wife, Christina developed holotropic breathwork ". . . a powerful method of self-exploration, personal transformation and healing. . .It is based on and combines insights from modern consciousness research, depth psychology and various spiritual practices. Through breathing, evocative music, and focused release work, non-ordinary states of consciousness are induced. These states allow mobilization of the spontaneous healing potential of the psyche. . . Holotropic breathwork mediates access to all levels of the human psyche including unfinished issues from postnatal biography, sequences of psychological death and rebirth, and the entire spectrum of transpersonal experiences."

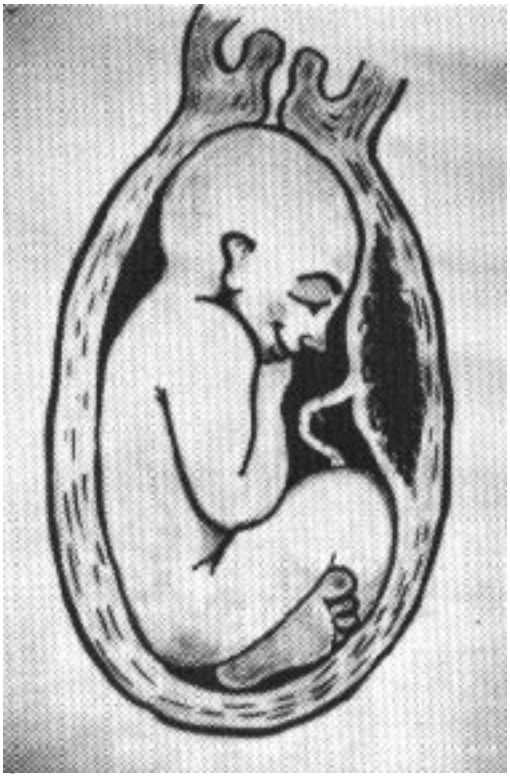
– John A. Speyrer, editor, The Primal Psychotherapy Page [The quoted material above is from a brochure of Dr. Grof]

In order to comprehend the following article, it is necessary to understand two theoretical concepts developed by Dr. Grof:

1. The BPM (basic perinatal matrix) and
2. COEX (systems of condensed experiences)

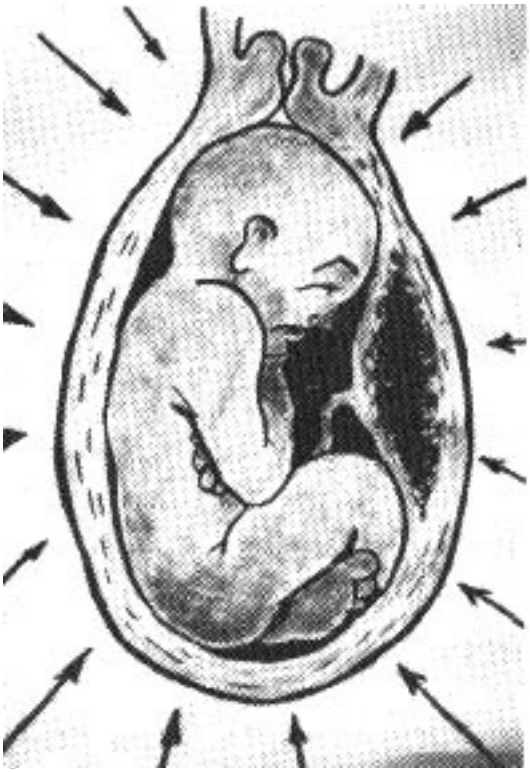
Basic Perinatal Matrices

(BPM): are general experiential patterns related to the stages of biological birth. These BPM are used here as a theoretical model, and not necessarily implying causal nexus.



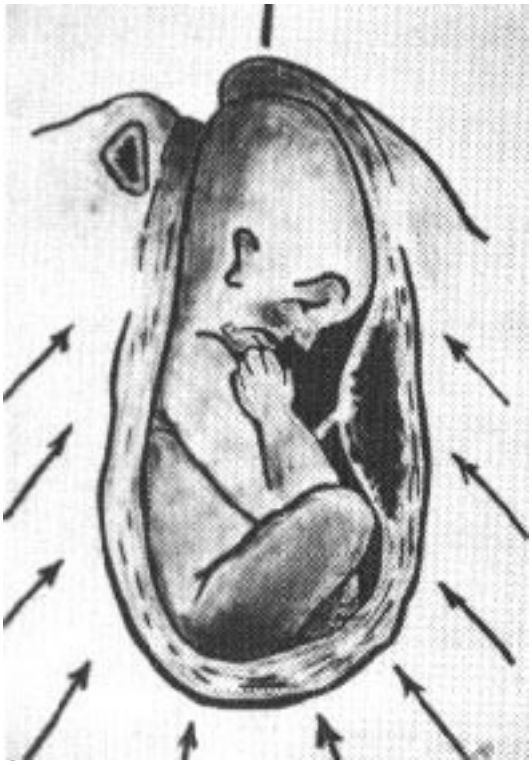
BPM I: – Primal Union with Mother. (Intrauterine Experience Before the Onset of Delivery.)

This matrix is related to the original condition of the intrauterine existence during which the child and his mother form a symbiotic unity. Unless some noxious stimuli interfere, the conditions for the child are optimal, involving security, protection appropriate milieu and satisfaction of all needs. This symbiotic unity can have both a disturbed and an undisturbed nature.



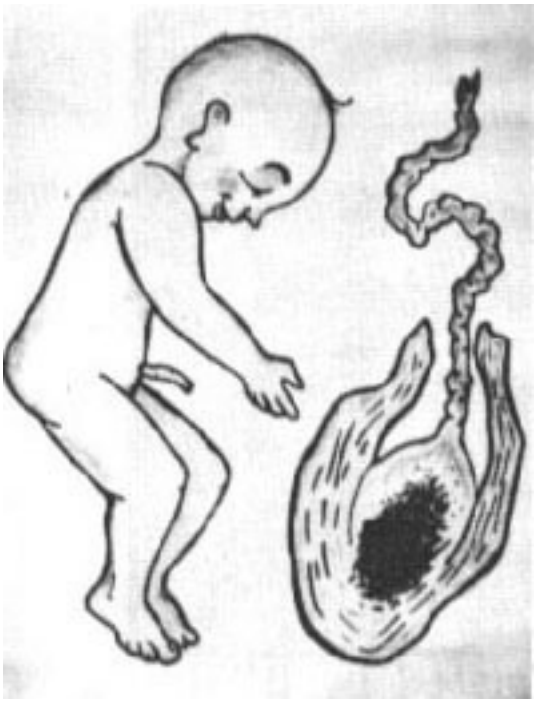
BPM II: – Antagonism with Mother. (Contractions in a Closed Uterine System.)

This matrix is related to the first clinical stage of the delivery. This episode belongs perhaps to the worst experiences a human being can have. The fetuses both mechanically and chemically alienated from the mother with no possibility of immediate escape which may be later manifested as feelings of being trapped, of being hopelessly caught and overwhelmed.



BPM III: – Synergism with Mother. (Propulsion Through the Birth Canal.)

This matrix is related to the second clinical stage of delivery. The uterine contractions continue, but the cervix stands wide open and the gradual and difficult propulsion through the birth canal begins. There is an enormous struggle for survival, mechanical crushing pressures and high degree of suffocation. The system is not closed any more, however, and a perspective of termination of the unbearable situation has appeared.



BPM IV: – Separation from Mother. (Termination of the Symbiotic Union and Formation of a New Type of Relationship.)

This matrix is related to the third clinical stage of delivery. In this phase the agonizing experiences of several hours culminates, the propulsion through the birth canal is completed and the ultimate intensification of tension and suffering is followed by a sudden relief and relaxation.

COEX: Systems of Condensed Experience: – A COEX system is a specific memory constellation comprising in a condensed form experiences (and/or fantasies) from different life periods of the individual. Memories belonging to a particular COEX system have a similar basic theme or contain similar elements and are accompanied by a strong emotional charge of the same quality.

It should be understood that the COEX systems are generally sub-ordinated to the BPMs, but they show a great degree of relative functional independence.

The attempt to relate psychopathology to the birth trauma or even to intrauterine experience is not entirely new in depth psychology. Sigmund Freud mentioned in his "Introductory Lectures to Psychoanalysis" the possibility that the anxiety experienced in the birth canal might be the basic model for all future anxieties. He has not, however, elaborated further on this idea.

Numerous references can be found. in the psychoanalytic literature to biological birth or intrauterine existence: these phenomena presented frequently by the patients are usually considered fantasies rather than real recollections. There are exceptions to this rule; it is necessary to mention in this connection the work of the Dutch psychoanalysts, Nandor Fodor and Litaert Peerbolte, Barbara Low, who coined the term "oceanic feelings", tried to use the primitive intrauterine experience for explanation of certain phenomena, for which the psychoanalytic framework seemed too narrow. C.G. Jung attributed great significance to the experience of rebirth, but used this concept in a purely psychological and spiritual framework and did not relate it to biological phenomena.

The most systematic and brilliant attempt to incorporate the fact of the trauma of birth into the psychoanalytic doctrine was made by Otto Rank. It was mentioned elsewhere that many of his assumptions could be used as a framework for understanding the phenomena of the stage of the LSD treatment where the patients dealt with the death and rebirth experiences. On the other hand, however, his concept of the birth trauma is very different from that obtained from the LSD sessions.

Rank's emphasis is on the element of separation from mother; the real trauma is to leave the warm maternal womb and be thrown into the cold and hostile world. The LSD research seems to suggest that a much more fundamental psychotraumatization can be seen in the hours of vital emergency and agony that is interpolated between the two mentioned conditions.

The richness, dynamic nature and depth of the material from repeated LSD sessions (as compared with the relatively superficial and often ambiguous material from the psychoanalytic treatment) makes it possible to study in detail the "perinatal area", map the territory and study its relations to psycho-pathology.

We do have to use the material from serial LSD sessions to see the serious logical contradictions in the present approach to the earliest periods of development. Many analysts accept without reservations the fact that very early nursing experiences can influence the future development of an individual in a decisive way (e.g., in the direction of sociopathy or schizophrenia). On the other hand, they do not take into consideration the immediately preceding hours of vital emergency, agony and utmost physical suffering with fight for breath, perhaps because the experience of birth is so all-human.

It is somehow silently accepted that the delivery means suffering for the mother, but is hardly experienced on a subjective level by the child. It is hard to imagine, however, that a child that has not subjectively registered hours of vital emergency could distinguish shortly thereafter a “good breast” from a “bad” one or be affected by various other nuances of mothering. It seems to make sense to attribute importance to early sucking experiences only if we simultaneously accept the paramount importance of the birth trauma.

All speculations about subtle traumatization in the first months of life seem to be absurd if the traumatic effect of the birth is denied. If the birth trauma is experienced subjectively, then it is on a completely different level of importance than any later psychological traumatization. It is a situation involving vital emergency, fight for breath, imminence of death and is comparable only to other situations involving agony and dying.

The biological significance and depth of this experience suggests that it could be recorded in old structures of the brain. The only objection against the possibility of birth memories is the fact that the cortical pathways are not yet myelinized; it is not, therefore, relevant unless we exclude the possibility that the birth imprints can be stored in subcortical areas. The material from the LSD sessions supports the psychoanalytic theories emphasizing the importance of the early oral period, but at the same time suggests strongly the unique and fundamental importance of the birth trauma.

The complex of emotional and biological phenomena experienced during birth could represent a very natural and logical matrix for all future psychopathology. This is obvious at least for several important facets of this experiential complex. Intense anxiety would be due to a high degree of survival threat and pain associated with the birth situation. Aggression amounting to the point of biological fury seems to be a natural reaction to threat and prolonged frustration.

This situation could also provide a natural basis for Freud’s understanding of depression as aggression turned against the individual. The closed system would prevent any external manifestations of aggression and transform it into the experience of depression. The tremendous amount of neuronal impulses that were generated by the emergency situation and could not reach the periphery, could be stored in closed neuronal circuits and account in the future for experiences of excessive tension, aggressive outbursts, impulsive behavior or even belated seizure-like muscular discharges. The helplessness of the situation of the child confronted

with brutal and elemental forces of birth could represent the deepest basis for future inferiority.

Very interesting is the problem of agonizing guilt that is always associated with the reliving of the birth complex; the reasons for this fact seem to be rather obscure. It seems that the feeling of guilt might be derived from the sequence of a blissful and extremely painful experience, as an artifact of search for causal explanation of a seemingly absurd and irrational event.

The typical physical symptoms accompanying various psychopathological manifestations can be very logically derived from the birth experience (belt headache, difficulties in breathing, various cardiac complaints, nausea and vomiting, muscular tension and twitches, hot flashes and chills, sweating, and constipation or diarrhea.

The birth experience could thus represent a multifaceted universal matrix present in all human beings who experienced the biological birth (as compared with people born by primary Caesarean section). Whether psychopathology develops and what particular form of it would then entirely depend on postnatal experiences of the individual (the COEX systems). Good mothering and predominance of positive childhood experiences would form a barrier between this matrix and the ego. Continuation of traumatic experiences would on the other hand facilitate the manifestations of various facets of the birth experience. Selective activation of particular facets would entirely depend on the nature of the pertinent COEX systems (involving experiences of oppression, depression, guilt, inferiority, and others.)

After this general outline we can try to apply the concept of BPM and COEX systems to the most important diagnostic categories of emotional disorders. Severe depressions of an endogenous nature or deep reactive depressions seem to be based on the second perinatal matrix.

The phenomenology of BPM II in LSD sessions as well as clinical symptomatolgy in the post-session intervals dominated by this matrix shows most of the essential features of depression: general motor inhibition, agonizing mental pain and suffering, anxiety, overwhelming feelings of guilt and inadequacy, absolute lack of zest, selectively negative perception of the world and one's own life, black and white perception of the world without colors, and feelings of an unbearable and inescapable life situation with no hope of any solution.

Also the physical manifestations of depression are in agreement with this concept:

feelings of oppression and constriction, loss of appetite and rejection of food, retention of urine and feces, inhibition of libido, headaches, cardiac distress, subjective breathing difficulties and various physical complaints interpreted occasionally in a hypochondriacal way. The suicidal ideation of this condition has typically the form of a wish not to exist, to fall into a deep sleep, forget everything, and not to awake the next day.

The COEX systems related to BPM II, and mediating its connection with the ego involve in basic agreement with the Freudian model episodes of early oral frustration in infancy, emotional deprivation in infancy and childhood, and various traumatic events in which the subject played the role of passive victim.

Family situations which are oppressive for the individual, and do not allow him any type of rebellion also belong to this category. A very typical and consistent part of these COEX systems are also experiences involving threat to survival and body integrity. It seems that the psychotraumatic aspects of serious diseases, injuries, operations and episodes of near drowning have been grossly underestimated in dynamic psychiatry as possible pathogenic factors in depression.

In contradistinction to the inhibited and often tearless depressions described above, agitated depressions seem to be related to BPM III. The basic features of this type of depression are a high level of anxiety and tension, aggression oriented both inwards and outwards, and excessive psychomotor excitement. The patients cry and scream, roll on the floor, flail around, beat their heads against the wall, and tear their hair and clothes

The suicidal ideation and tendencies involve bloody and violent actions. The COEX systems reinforcing this matrix deal with violence and aggression, cruel treatment, rape and other forms of sexual abuse; the common denominator of these situations is that the subject experienced them in an active role trying to escape or fight.

As far as mania is concerned, it can be placed in this scheme as a transitional manifestation between the third and fourth perinatal matrix. The clinical picture of mania was occasionally observed in LSD sessions and post-session periods; it could be considered an expression of incomplete “rebirth.” The subjects showing this symptomatology have already moved beyond the difficult experiences of BPM III and experienced a superficial escape from the birth agony.

There was, however, still a powerful stream of underlying anxiety and tension and the patients were trying to run away from the unresolved unconscious material. In

such a case the new positive feelings were exaggerated to the point of a caricature and used as a defense against the inner threat. These patients were overactive, moved around in a hectic way, tried to socialize and fraternize with all the persons in their environment, presented grandiose plans and demonstratively emphasized their wonderful feelings.

When LSD treatment was continued, these exaggerated manifestations disappeared after the full reliving of the birth. The experiences related to the uncontaminated BPM IV do not involve any tension and impulsive drives; they are peaceful, quiet and non-ostentatious.

It seems that the memory recordings of the sequences in biological birth with a sudden shift from agonizing feelings to an experience of dramatic relief could represent a deep natural basis for the episodic and periodic nature of depressions as well as for the occasional occurrence of mania.

It should be mentioned in this connection that the concept of perinatal matrices seems to suggest a new and interesting way of looking at the phenomenon of suicide and especially at the rather obscure problem of the choice of the method of suicide. Suicidal ideation and tendencies can be observed occasionally at any stage of the LSD treatment but in psychiatric patients who are dealing with the birth agony the suicidal problems are quite frequent and urgent.

The observations from the LSD research seem to suggest that the suicidal tendencies fall into two rather distinct categories that have specific relations to basic perinatal matrices. The hypothetical relation between the problems of suicide and the stages of biological birth offers a natural basis for the understanding of suicide. If we accept that the unbearable situation that the depressed patients experience is related to BPM II (inhibited depression) and BPM III (agitated depression) as hypothesized above, then the efforts to escape from it by suicide seem to follow two basic patterns:

Suicide of the first type represents unconsciously a regressive effort to return into the original intrauterine situation (perinatal matrix I). As the real motive is unconscious and not accessible, the subjects try to use some means that can induce a similar condition -namely reduction of the painful stimuli and their eventual elimination, lowering of the level of consciousness to the point of losing individual awareness of the world moving into an undifferentiated state and “forgetting everything.” This group includes suicidal plans and attempts using large doses of hypnotics or ataractics, inhalation of carbon monoxide, or illuminating gas, bleeding in warm

water ‘ drowning, or freezing in snow (it is known that after a period of suffering freezing, persons experience agreeable warmth and fall into a ‘condition resembling sleep). These phenomena were frequently reported as fantasies or even tendencies by subjects reliving birth, when their experiences were related to the phenomenology of BPM II.

Suicide of the second type follows unconsciously the pattern, once actually experienced during birth. During the actual delivery the final liberation comes after the suffering and tension has increased, culminated and been transcended. This type of suicide seems to be in close connection with the agitated form of depression and associated with BPM III. The subjects here feel a strong urge to end an unbearable situation at the expense of a bloody catastrophe and tremendous release of tension and aggression. Bloody suicides thus seem to represent a dramatic re-enactment of the situation occurring at birth and can be seen as the result of tragically misunderstood craving for delivery-deliverance. This category includes suicidal plans or tendencies involving death under the wheels of a train, in the turbine of a hydroelectric plant, throwing oneself from a window, tower or high rock, cutting one’s throat, blowing out one’s brains, stabbing oneself with a daggar, harakiri, kamikaze or suicidal auto accidents. The suicide by hanging seems to be related to an earlier phase of the third perinatal matrix characterized by elements of strangulation, suffocation, agony and in terminal moments also libidinal feelings. This combination of agony and sexual ecstasy is well known from reports of subjects, who attempted to hang themselves but were rescued. Similarly, the fact of frequent erection and even ejaculation in criminals executed by hanging can be used as illustration of this point.

As far as the problem of motivation for suicide is concerned, it is interesting to mention that in our subjects all the feelings related to particular ways of suicide preceded the pertinent tendencies. Thus, on occasion, LSD subjects sessions or free intervals the feelings of being crushed or torn to pieces, strangulated and suffocated or stabbed before the occurrence of specific suicidal fantasies or tendencies.

It seems that the mechanism of suicide might be explained by a similar principle to the one described for the COEX systems, namely by a general tendency to exteriorize irrational feelings and attach them to a corresponding reality situation. The enactment of a particular suicidal situation might be the result of a tendency to attain congruency between pre-existing inner feelings and objective reality. The awareness of a profound discrepancy between the two seems to be more unbearable than the self-destructive act that terminates this painful affective cognitive dissonance.

All the mentioned phenomena are quite common in patients reliving their birth experiences and the mentioned connections were observed in their sessions and post-session intervals. As LSD therapy advanced and subjects transcended the perinatal area, they gained insight into the dynamics of their previous suicidal tendencies and fantasies. Again and again did LSD subjects independently offer the following explanation of suicidal drives in their retrospective analysis: The tension which they experienced was reaching unbearable proportions and they developed a strong feeling that something explosive must happen that will bring the final liberation.

Before they discovered that this liberation was really connected with the complete reliving of the birth agony and reaching freedom of the intrauterine or neonatal consciousness, the craving for liberation was misinterpreted as craving for death and physical destruction. Deep psychological need for ego death and transcendence which form an integral part of the rebirth experience thus masqueraded as suicidal tendencies before the real nature of this craving was recognized and acknowledged.

In general agreement with the psychoanalytical theory alcoholism and drug addiction seems to be closely related to depression. The deepest roots of these two conditions lie also in BPM II. The most typical characteristic of these patients and at the same time the deepest motive for taking intoxicant drugs seems to be a strong craving for experiences of blissful and undifferentiated unity that the child experiences during undisturbed intrauterine life and nursing.

The excessive consumption of alcohol or drugs respectively can be understood as a mitigated analogon of suicidal tendencies of the first type aimed unconsciously at achieving the elements of the first perinatal matrix. It seems that in depressed patients, alcoholics and drug addicts it is generally relatively easier to elicit psychedelic experiences in a short-cut way than in other diagnostic categories. Deep psychedelic experiences seem to satiate the underlying craving for unity and reduce the necessity to abuse alcohol and drugs. Alcoholic patients and drug addicts after having had the experiences of unitive ecstasy related to BPM I, quite frequently report the insight that this is the condition they have been trying to achieve through alcohol and drugs. The latter, have, however, proved to be an inadequate means for this goal. Like suicide, alcoholism and drug addiction seem to represent unrecognized misunderstood and distorted need for transcendence.

Several important manifestations of sexual deviations seem to be directly related to BPM III. This is especially true for sadomasochistic phenomena, characterized by a peculiar fusion of aggressive and libidinal feelings. This combination represents an

essential part of the third perinatal matrix and has probably a very natural physiological basis; one such possibility would be for example, simultaneous activation of limbic structures related to self-preservation and those related to preservation of the species or spillover of neuronal excitation from the former to the later.

An attempt to explain these phenomena within the usual psychoanalytic framework presented special difficulties as exemplified by Freud's study, Beyond the Pleasure Principles. The specific features of sadomasochistic manifestations as well as the close relation between their sadistic and masochistic aspect are well understandable from the nature of the third perinatal matrix.

The alternation between the role of the suffering victim and the cruel aggressor, as well as suffering culminating and transcending into ecstasy, are both very characteristic and typical for this matrix. Even if it is most clearly expressed in sado masochistic patients, the potential to transcend extreme suffering into ecstasy seems to be inherent to the human nature.

It was described not only for martyr deaths of saints in Middle Ages, but also in modern time under such conditions as torturing the prisoners by the Nazis or Japanese soldiers. It is also interesting to mention in this connection that intense physical suffering has been frequently used in the past as prerequisite for religious ecstasy (which is also typical for experiences related to BPM III). So, for example, flagellants of all ages used cruel whipping and other forms of self-torture and automutilation as a means for achieving religious enlightenment. According to the description the suffering often changed into pleasant excitement not dissimilar to sexual feelings and finally culminated in religious ecstasy. The pictures of processions of flagellants often appeared in LSD sessions dominated by BPM Ill.

Also male homosexuality seems to be related meaningfully to the birth trauma, especially to the third perinatal matrix. The fear of female genitals, explained in psychoanalysis by the castration complex based on infantile fantasies about vagina as a dangerous organ (vagina dentata) seems to be on a deeper level related to the biological fact that the female genital is a potentially murderous instrument that was once actually a source of agony and vital threat. It can not, therefore, become a source of sexual pleasure if the unconscious memory of birth is too vivid. The fear of heterosexual sex was in these patients often accompanied by a deep craving for warm non-genital contact with the maternal figure on a very primitive level (anaclitic needs).

As far as female homosexuality is concerned it appears to be more superficial; in LSD treatment it could usually be traced back to deep levels of COEX systems and BPM IV. Deep roots for Lesbian needs and tendencies seemed to be in unsatisfied craving for close contact between mother and daughter during early infancy and the association between the oralgenital contact and the orgiastic release at birth. In addition, very important traumatic memories could usually be recovered in which the male sexual object was associated with danger, guilt or humiliation.

The obsessive-compulsive neurosis seems to have the deepest roots in BPM III. The fact that conflicts in regard to homosexuality and aggression as well as inhibition of genitality belong to the most important problems found in these patients, is in good agreement with this assumption. The relation of homosexuality to birth anxiety was already demonstrated above. The inhibition of genitality seems to be in the last analysis due to a similarity between the pattern of sexual orgasm and negative aspects of the third perinatal matrix. Thus attempts to control aggression and anxiety bound to this matrix inhibit also the pattern of sexual response.

Another typical characteristic of obsessive-compulsive patients supports the mentioned view, namely a very specific attitude toward religion. Many typical obsessive-compulsive patients are in constant conflict in regard to religion, alternately rebelling and blaspheming against a punishing God of the Yahve type and contrariwise trying to undo and expiate their trespasses and sins. This type of problem was quite regularly related in LSD sessions to the last phases of the birth agony; where ultimate surrender to an overwhelming force alternated with passionate revolt, aggression and agonizing guilt. In addition this was happening on the general background of the awareness of the cosmic relevance of this situation and anticipation of the possibility of salvation. The restricting external force in this phase (the birth canal) seems to represent the deepest instinctual root of the future Superego (the violent part of the Superego that psychoanalysis derives from the Id).

Conflicts surrounding excretory functions and toilet training (reinforcing the aspect “cloacal discharge” during delivery), problem with parental authority, and a specific strongly ambivalent close symbiotic relationship with mother represent the typical themes of the COEX systems underlying this neurosis.

As far as the so-called pregenital conversions are concerned, the basic personality structure associated with them seems to have important obsessive-compulsive features. The leading symptoms in the separate clinical pictures are related to BPM III. In psychogenic asthma the main symptom can be traced back to agony and suffocation during delivery’. In maladie des tics the muscular twitches are due to

discharges of tension accumulated during delivery in closed neuronal circuits and perpetuated in later life by specific events.

Psychogenic stammering seems to be related to conflicts in regard to oral and anal aggression, the deepest roots of which can be found in last analysis in the pressure on locked jaws during the passage of the head through the birth canal and in anal tension resulting from heightened intraabdominal pressure respectively.

In conversion hysteria the most dramatic manifestation -the major hysterical seizure and other manifestations of muscular hyperactivity are related to BPM III. In the hysterical seizure the particular combination of tension, psychomotor excitation, breathing difficulties and aggressive-depressive affect as well as the striking similarity with sexual orgasm supports this view. The same is true for the characteristic arc de cercle, so frequently observed in LSD subjects experiencing birth. Hysterical paralysis and other conversion symptoms seem to be based on conflictual innervations of opposite direction during delivery as well as during specific later situations. As already stressed by Otto Rank, the problem here does not seem to be how psychological conflicts resulted in somatic manifestations, but how originally somatic phenomena later acquired psychological and symbolic meaning.

Some deep hysterical phenomena, such as stupor, hysterical hallucinosis, uncontrolled daydreaming and mistaking of fantasy for reality, are probably related to BPM I and are based on a deep need to reinstitute the situation typical for this matrix. In basic agreement with the psychoanalytic model the specific psychotraumatic experiences characteristic for this disease (COEX systems) are related to the phallic stage of libidinal development. The Oedipus and Electra complex, and various other aspects of the sexual history.

In anxiety hysteria the emotional component can be traced back directly to primal anxiety during delivery. The choice of the objects and situations to which anxiety is attached reflects some specific aspects or facets of the birth trauma, emphasized and approximated to the ego by later life experiences. The relation to the birth trauma is most evident in the case of claustrophobia (fear of closed spaces) which can be directly traced back to the oppression in the restricting uterine system.

Similarly thanatophobia (fear of death) can be easily related to experiences of agony and vital anxiety, which are a regular part of the birth trauma. It is also not difficult to find the direct relation to the birth trauma in case of the phobia of pregnancy. In the phobia concerning child care (fear of hurting the child usually combined with a compulsion to do it), the deepest roots of aggressive feelings toward the child and

antagonism with it can be traced back to the situation of delivery of this child when the mother and child were hurting each other. This situation activates the mother's own unconscious memory of a similar situation during her birth. In cancerophobia (fear of cancer) and nosophobia (fear of diseases) in general, the birth anxiety together with various somatic sensations and pains experienced during delivery can be found in the last analysis. The relation of cancerophobia to unconscious conflicts around pregnancy is well known from psychoanalysis.

A similar explanation can be suggested for certain types of hypochondriasis. In cancerophobia also the unconscious identification of the malignant growth with embryonal development as well as the uncanny character of cancer seems to play an important role.

In bacillophobia and mysophobia (fear of microorganisms and dirt), which is frequently associated with compulsive washing, the combination of vital anxiety, aggression and contact with biological material during birth seems to be essential. These patients usually not only fear that they will infect themselves, but that they will cause disaster by infecting others. On a more superficial level the fear of bacterial growth and infections is unconsciously related to spermatozoids and conception, and hereby indirectly again with the birth situation. From later experiences conflicts concerning toilet training and cleanliness seem to be very important.

In phobias of heights and bridges the suicidal urge of the second type and fight against it seems to be involved. A strong compulsion to throw oneself from the roof, tower, rock or jump from the bridge into water usually underlies all phobias of this type. In street phobia and agoraphobia (fear of open space) the changes of space relations seem to be important- subjective sensation of narrowing and broadening of space. In street phobia, in addition, the traffic seems to symbolize the vital danger during birth, but an important element of sexual tension is usually added that results in a fear of promiscuous contacts in the streets and of impulsive exhibitionistic exposure to the public. In many subsequent sessions in these patients sexual orgastic feelings can completely dominate the picture and later deepen into the experience of agony and rebirth. This unfolding is based on the similarity between birth agony and the sexual orgasm.

The relation of animal phobias to the birth trauma was already clearly demonstrated by Rank. In the case of large animals the element of swallowing and incorporation seems to be of importance (wolf), as well as the relation to pregnancy (cow). In the case of small animals the possibility to enter narrow holes in the earth and leave

them again is probably a significant factor. Some small animals seem to be besides associated with some special problems. So for instance spiders, with their ability to wrap the victim into the web and kill it, appeared in a giant form quite frequently as symbols for bad mother in the sessions dealing with birth, thus suggesting the importance of this area for the development of future arachnophobia (fear of spiders). Similarly, snakes besides having on a more superficial level an evidently phallic significance, are on a deeper level typical symbols for the birth agony and thus for evil female element.

The real substantiation for this seems to be the observations of large constrictors, who can strangle and crush the victim (birth agony) and then swallow it in its totality (pregnancy). There seem to be, however, very deep archetypal roots for this symbolism. As far as small insects are concerned, bees seem to be specifically related to the problem of reproduction and pregnancy (carrying of pollen, swelling induced by the sting). The flies because of their ability to contaminate and to spread infection are associated usually with sperms on one side and postpartum dirt on the other. They seem to have a special relation to phobia of dirt and microorganisms.

Also emotional disorders with somatic manifestations seem to be based in their deepest layers on perinatal matrices. Thus psychogenic enuresis and encopressis (neurotic loss of control over bladder and bowel movements) are related to BPM III, where urination and defecation can occur as a reflex reaction to high degree of pain, suffocation, vital anxiety and heightened intrabdominal pressure. A replica of this situation can be observed even in adults in extraordinary situations such as attacks in war, accidents, or other instances of sudden vital danger. In subjects reliving birth in the LSD sessions concern over control of sphincters is a regular occurrence and occasionally real bedwetting can be observed. Reports about soiling the bed in the sessions also exist, but they are extremely rare.

Severe sexual neuroses such as frigidity, impotence and orgastic impotence seem to be based in last analysis on the similarity between the pattern of sexual orgasm and the birth agony (BPM III). The orgastic ability seems to be blocked by strong admixture of aggression in the form of sadomasochistic impulses and vital anxiety attached to the birth trauma. In general the ability of final relaxation and satisfaction after the orgasm is deeply related to the ability to achieve feelings of peaceful ecstasy in the LSD sessions (BPM I and IV) and is greatly enhanced, whenever the subject reaches this level of LSD psychotherapy. The organ-neurotic symptoms (headaches of a typical belt character; nausea and vomiting; irritability of bowels and diarrhea: suffocation and feelings of lack of oxygen: cardiac distress and palpitations; sweating; blushing; chills and hot flushes; and muscular twitches can be traced back

to the complex of somatic phenomena, which form a logical and understandable part of the birth experience.

A different vegetative syndrome involving bad tastes in the mouth and "hangover" or "flu" symptoms (inner trembling and feelings of cold; weakness; dyspepsia with flatulence and constipation; vegetative dystonia and subtle trembling of isolated muscles) appears in the sessions and free intervals in subjects, who already passed the point of ego death and rebirth. These manifestations can be related to disturbances of intrauterine life. The same feelings seem to be the basis of hypochondriasis based on strange, hardly definable somatic sensations.

There seem to be enough data in our clinical material as well as in the LSD literature for the assumption that BPM II and III are involved also in the pathogenesis of serious psychosomatic diseases, like asthma, psoriasis, peptic ulcer, ulcerous colitis and arterial hypertension.

Neurasthenia and the emotional traumatic neuroses deserve a special notice because in these disorders the components of BPM III Appear in the original form, not too much modified by later life experience (COEX systems). Neurasthenia seems to be the most common and normal reaction of an individual, living for a longer time period in an objectively stressful situation.

The symptoms observed under these conditions seem to represent the typical birth phenomena in a mitigated form: intense headaches, muscular tension, sweating, cardiac distress and palpitations, oppression, diarrhea and "faiblesse irritable" (feelings of weakness, but at the same time tension and easy irritability).

Sexual disturbances that are a rather constant component of this clinical picture (impotence in males and orgastic difficulties in females) could be explained by the described relation between BPM III and the pattern of sexual orgasm. In the emotional traumatic neuroses the situation precipitating the symptoms resembles the original birth situation in that it represents a real threat to survival and body integrity and involves vital anxiety (air raids and attacks in war, accidents, and operations).

Different manifestations of schizophrenia are related to various perinatal matrices; it seems, however, that the emphasis is in most cases on BPM I, the primal union with mother and on transpersonal elements. Exceptionally some schizophrenic patients can have episodes of relatively pure ecstatic feelings of communion with God, meeting many of the criteria of Pahnke's mystical categories. Rather than being

understood as a universal manifestation, as it is usually the case for religious teachers and mystics, they are interpreted by these patients within the framework of grandiose delusions of uniqueness. Instead of viewing their experience with humility as manifestation of potential inherent in every human being they tend to declare themselves as God or one of His prophets and try to convince others that they deserve special treatment.

On the other hand they feel frequently persecuted, and spend much time and energy fighting their real or imagined opponents and adversaries. Basically, the difference between the experiences of mystics and schizophrenic patients does not seem to be primarily in the nature and content of the experiences, but in the general approach to these experiences and their integration into everyday life. Also the interest in mystical, philosophical, religious and cosmological problems and reincarnation, which is so frequent in schizophrenic patients, is a typical manifestation of BPM I and the trans-personal realms of the unconscious.

Clinical material from advanced LSD sessions indicates that catatonia and stupor of schizophrenic patients, frequently associated with the fetal position and disregard for intake of food or the excretory functions seem to be related to the intrauterine situation. The experiences of disturbed intrauterine existence in LSD sessions are accompanied by many phenomena essential for schizophrenia (bizarre somatic symptoms attributed to the influence of evil metaphysical or cosmic forces, to the action of noxious radiation, or to chemical influences, such as gases or poisons). This can be associated with visions of insidious and dangerous demons, which the subject has to fight against.

These episodes, as well as the adverse biochemical changes heralding the onset of delivery, seem to be the basic matrix for feelings of universal undefined danger and threat, typical for paranoid patients. The experiences of external influence (e.g. by machines or hypnosis) as well as intrapsychic and acoustic hallucinations seem to be related to the original, undifferentiated symbiotic union with mother. The wishful delusions and elements of uncontrolled daydreaming and autistic thinking can be understood as resulting from an attempt to reinstitute the original undisturbed intrauterine situation.

The participation of the third perinatal matrix seems to add to the picture of schizophrenia especially the elements of bloody aggression and sado-masochistic elements such as experiences of physical tortures attributed to evil entities, persecutors, or a diabolic machine and auto-mutilation or murder. Some other features characteristic of BPM III involve episodes of sexual tension, wild ecstasy and

other sexual manifestations, bizarre motor phenomena, bouts of panic anxiety, but also not infrequent spontaneous episodes of ego death and rebirth, experiences of destruction and recreation of the world, feelings of identification with Christ, or salvation and resurrection.

All the mentioned elements of the perinatal matrices have been activated and approximated to the ego by various traumatic experiences from different periods of the schizophrenic's complicated life history. This could explain the frequent occurrence of childhood material in the symptomatology of schizophrenia.

The basic difference between the experiences of psychotic and neurotic patients from this point of view seems to be the fact that the former are under a more or less direct influence of the elements of perinal matrices, whereas the latter are tuned into various levels of COEX systems and the perinatal levels participate only as a transphenomenal source of emotional energy for the symptoms. It is reasonable to assume that in different stages of schizophrenia also various biological, especially biochemical factors might be involved, contributing to the activation of COEX systems and eventually perinatal matrices.

Another interesting problem upon which the observations from LSD sessions can shed some new light concerns the relation between the female reproductive functions and emotional disorders. This concerns above all the precipitation of mental disorders in pregnancy and the postpartum period. Because of the described deep similarity between the pattern of birth agony, sexual orgasm and delivery of a child, the experience of giving birth to a child seems to activate the unconscious memory of the mother's own birth (see the parallel reliving of both in LSD sessions).

It also activates all the later secondary elaborations of perinatal matrices that form part of the appropriate COEX systems. Also the typical problems connected with menstruation and sex in general seem to be related to the birth phenomena.

Many of these phenomena probably have very important psychological interconnections, up to now unexplored and insufficiently understood. The hormonal dysbalance, that is so frequently considered the single most important factor in mental disorders occurring in puberty, menstruation, pregnancy, puerperium and menopause, appears from this point of view to be of secondary significance.

One more interesting area should be discussed in relation to the birth trauma and perinatal matrices. It seems that the observations from LSD sessions could contribute to our understanding of the phenomenon of ecstasy. Similarly, as we could

distinguish two groups of suicides and relate them to different perinatal matrices, we can also identify two broad categories of ecstasies.

Wild and dynamic ecstasy of the "volcanic type" is a sensual type of ecstasy with a strong component of inner tension, sexual excitement and aggression. It is related to rhythmic dances characterized by intoxicating monotony and a sexual undertone, to loud music with a distinct beat, to fire, fireworks, explosions, rich colors and amusement parks. Also ritual dances with the unique mixture of sexual and religious elements could be mentioned in this context. A deep and intense form of this type of ecstasy involves physical and emotional pain and borders an agony with religious expectations of a large event-liberation redemption, salvation, rebirth. The experiences from LSD psychotherapy show clearly that this type of ecstasy is related to BPM III. The experience of the sexual orgasm and delivery of the child belongs to this category.

Peaceful and harmonious ecstasy of the oceanic type is a spiritual type of ecstasy, a tension-free condition with experiences of ego loss, identification with the Universe and God, with essential qualities of love, light and security. It is related to gentle, fluent dance such as classical or oriental ballet, slow, calm and peaceful music or, — solemn choirs, natural beauties (blue or star-filled sky, high mountains, clear lakes, and ocean), harmonious pastel colors, radiant light or gentle and subtle ornaments.

On a more superficial level it sometimes involves elements of anaclitical satisfaction (good womb or good breast) and sexual gratification and fulfillment. It represents a condition where all the needs of the individual seem to be satisfied. The experience of total relaxation, fusion, and male-female union following the sexual climax and the feelings of the mother after delivery of the child belong to this group. Most of the peak experiences in Maslow's sense could be classified in this category. Genetically this type of ecstasy is related to the first and fourth perinatal matrix. The achievement of this condition and stabilization in this state seems to be the ultimate goal of LSD psychotherapy.

Fonte.