PERSPECTIVES ON PSYCHOTHERAPY

THE ORIGINS OF ANXIETY, PANIC AND RAGE ATTACKS

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Abstract

This is a report of clinical observations over forty-five years. We describe the difference between limbic fear versus brainstem terror. The earlier a patient relives events from childhood, and infancy, the deeper into the brain he may reach. In the process, the affective responses become more exaggerated; for example, mild hopelessness becomes suicidal hopelessness, fear becomes terror, and anger becomes rage. The responses become more primitive as they emanate from a brain that is more primitive; older and pre-human. (Janov, 2011) That primitive brain inside of us provides all of the responses that existed hundreds of millions of years ago. In some respects we are still that alligator or shark with no pity or remorse, just instinct. Those primitive responses are pre-emotion, before mammalian caring and concern evolved, and they do allow us to murder when evoked. They also permit panic attacks which evolved to be life-saving in situations where rapid and vigorous responses meant survival. A person responding with rage or terror is overwhelmed by his brainstem activity and is reacting exactly like the alligator does. These deep and early processes have largely been ignored in clinical work and must be revisited.

Key words: Anxiety; Limbic fear; Panic attacks; Primal therapy

1. INTRODUCTION

In my previous work, I have described the difference between limbic fear versus brainstem terror; that is, the earlier a patient goes when reliving events from childhood, and infancy, the deeper into the brain he reaches. In the process, the affective responses become more exaggerated; for example, mild hopelessness becomes suicidal hopelessness, fear becomes terror, and anger becomes rage. The responses become more primitive as they emanate from a brain that is more primitive; older and pre-human (Janov, 2011) the brainstem. That primitive brain inside of us provides all of the responses that existed hundreds of millions of years ago. In some respects we are still that alligator or shark with no pity or remorse, just instinct. Those primitive responses are pre-emotion, before mammalian caring and concern evolved, and they do allow us to murder when evoked. They also permit panic attacks which evolved to be life-saving in situations where rapid and vigorous responses meant survival. A person responding with rage or terror is overwhelmed by his brainstem activity and is reacting exactly like the alligator does (Panksepp, 1998).

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Those responses are often caused by a birth trauma where a 130 pound mother is given anesthesia that suppresses so many of the functions of a 6 pound fetus, including breathing. (Lewit, 2009; Singer, 2004, p141, 215-228). This combined with a mother who smoked to produce an oxygen deficit in the fetus. (Cannon, 2008, p. 797-802; Fent, 2008, p. 138-145) The breathing apparatus is impaired; that may be imprinted and endure for a lifetime. It is an imprint of impending death—terror. Fright becomes a permanent accompaniment. And phobias and compulsions may be the lifelong result.

What I am discussing are dangers for the baby that menace his life. His system reacts with terror because that is the highest level of brain development, at the moment, and because those events are most often life-threatening. Key biologic set-points are altered, leaving a vulnerability to disease later on. (This includes cortisol levels, natural killer cells as well as imipramine binding, all research we have done, and discussed in my Primal Healing) (Janov, 2007).

That heavy dose of anesthetics to the mother during the birth process can shut down the baby’s respiratory system and bring him near death. This is the time of rapid brain development where trauma can have long-lasting effects. It sets up a prototype and afterward can be the origin of migraines and high blood pressure, as the circulatory system is compromised. So later upset can trigger off a migraine as the vessels constrict as a defense, and a memory of what the vessels need to do physiologically when under threat — constrict. This is the same biologic reaction that produces pupillary constriction when viewing scenes of horror. We will discuss this further under the section called resonance (Hodie, 2010, p. 430-437).

For purposes of this article I will concentrate on lower brain processes, omitting the very important limbic system. It is what I call the first-line that has often been neglected or ignored. The second line processes feelings/emotions, while the third line is largely cognitive, intellectual and also processes belief systems. Though highly interconnected, each level has independent functions.

When I mention “going deeper,” it is specific to our Primal Therapy where patients over the many months do descend deeper in the brain and remote past to touch on (relive) those lower brains. We see that patients approaching first-line-brainstem imprints have major spikes in brain-wave patterns, blood pressure, body temperature and heart rate; the amount of change tells us on what level the patient is operating; radical alterations are inevitably first line. Not only that, but there are key behavioral effects: loss of breath, certain physical movements not excluding fetal position, bringing up a great deal of mucous, obvious suffocation, and more. They are in the grip of that lower brain structure. (For more on this, please read my Life Before Birth, Janov, 2011.) When we did brainwave studies years ago we found that a patient on the verge of first-line pain had skyrocketing brainwaves; amplitude of waves mounted as many more neurons were recruited to help with pain and repression. The latest study, the fourth was made under the direction of E. M. Holden (Janov, 1996).

There are two ways that we become in touch with first line. One, to be so fragile and defenseless that the deep imprints rise toward conscious/ awareness; or two, patients slowly descend over time (often months) to arrive at the first line. This is where panic lies, and we see panic surging forth as patients come in contact with brainstem imprints.

The panic victim feels threatened but he doesn’t know what he is afraid of. Or sometimes, that he is even afraid. It sometimes doesn’t feel like fear; it is some unknown feeling of fright that seems so alien. She is panicked over whatever lies in her brainstem. The reasons could be any number of things: a mother’s terror during pregnancy translated to her baby, suffocation and near death as the mother is given heavy doses of anesthetic during birth, a fright, as with one of my patients who was involved in a serious auto accident in her eighth month. When I was in graduate school I learned about antecedent-consequent reactions. All it meant was that if there is a response, something caused it. When there is rage and terror, something causes it. These are not ordinary reactions; they are primitive in the full meaning of the term. So far we have not known what that meant. The more we learn about the brainstem and
ancient parts of the limbic system, including the amygdala, the more we come to understand these exaggerated reactions.

We now are learning that so-called anger management therapy is useless against rage. Rage operates on a much lower level than cognitive-style therapy that focuses higher up. We don’t want to manage feelings; we want to feel them. But when there is no knowledge of deep levels we resort to management. Just another way of holding them down when they need to be expressed.

The central system, the brain and spinal cord, matures in sequence: from first line (the tail) and then higher (the head). And we relive in exactly the opposite manner: head before tail. Reverse evolution; we are governed by the rules of biology.

By the fifth week of gestation we find synapses are connecting nerve cells. A few weeks later the whole fetal body can curl, twist and turn. At ten weeks he can move his fingers. He begins to move enough to be recognized by the mother at about eighteen weeks. The emotional brain is developing in the last trimester and months after birth. What happens then affects our emotional life permanently. Damage during this time can sometimes lead to those who seem to have no feelings, no concern nor empathy – psychopaths (Anand, 2000, p 69-82; Kaplan, 2008, p. 249-256).

There is a question as to when we first become alert or conscious. It seems to be around the 24th week of gestation. That is when the thalamus and its nerve circuits to the cortex are in place; the cortex can get information from below. That may be the beginnings of global awareness.

There are three brains in our head. Thus the term The Triune Brain as outlined and explained by Paul D. Maclean, the grandfather of modern neurology. (Maclean, 1990) The first part of the brain to develop is what I call the “first line.” In the first line lies all of those instincts and primitive reactions. When there is trauma at birth or during gestation, long before we have an intact emotional brain, our reactions are coded and stored down on the first line. And when we ignore this level there is no chance of a cure because we have not gone deep enough in the brain, in the unconscious, to call it what it is: terror. As it wends its way to the top level we give it a name: anxiety. We then deal with anxiety attacks because we are unaware of their real name – terror – or their deep source – the first line.

There are plenty of attempts at improvement in conventional therapy, which is good, but the problem is obdurate, and will last a lifetime, as does the imprint that holds the memory in storage and also holds the symptom in its grip and won’t let go until generating sources are experienced. First line is the foundation for our personality. As it evolves it shapes or distorts the feeling and later the thinking systems.

According to the early work of Melzack and Wall, there is a gating system in the brain that has a specific function. Our clinical work finds the gating system has a different function from what they describe. It is mainly to block off pain and terror from reaching higher levels of conscious/ awareness. In brief, to keep us unconscious of threatening imprints. (Melzack &. Wall, 1965). Their work was the beginning of the gate control theory. When the baby suffers great trauma during those early times the gating system weakens and we have "leaky gates." The trauma, when excessive, causes the brain to use up major supplies of repressive chemicals, such as serotonin. This impairs the proper functioning of the inhibitory system, our defense system (Teicher et al., 2006). Not only does trauma exhaust serotonin, it damages parts of the brain that produce it, as well as damaging the production of dopamine and epinephrine. Tranquilizers tend to replace what was used up originally; serotonin is found in Prozac and many tranquilizers. Their function is to block serotonin uptake so we retain supplies over time. It seems that it is simply buttressing what was exhausted in the original battle.

When our pain levels are high, and therefore we are less defended, we may arrive at age thirty with a panic attack, which becomes a mystery. And it is a mystery because its origin lies deep in the brain. We can now understand its provenance: a remote nervous system. It is responsible for so much of our aberrant behavior as well as opaque and refractory symptoms. We now see in our clinical practice all those primitive instincts that surge forth when patients
descend deep in the nervous system. They keep us on the qui vive all of the time—alert when we should be trying to sleep, over-reacting when it is not called for. Freud called it hysteria (Breuer & Freud, 1895).

We see now that when we act in the present and there is a resonance down deep we react to both times at once: over-reaction. The resonance may be terror from a carrying mother who smoked and drank and who was effectively killing or damaging the baby from diminished oxygen. That and many other configurations conspire to inculcate terror in the baby that is imprinted and sealed in as a (primal) memory. When there is a panic attack or rage attack we must look to that brain for understanding and cure. It is only with that brain that we can find causes and answers.

It is not just anxiety that is apparent but serious mental illness, as well; the result of horrifying and inescapable experiences in the womb, (very early in womb-life). It is clear that the experience is inescapable when mother is infusing drugs into the fetus and lowering his oxygen. Patients down on that level (and I know how ridiculous that may seem to the uninitiated) exhibit again the terror. They feel like they are dying. They are indeed approaching death. That is the memory that endures and shows up years later when the gates weaken in panic attacks.

What is more important is that after a reliving, all key signs descend below baseline, as long as it is an actual reliving. This is never the case with those who are in abreaction (the release of the energy of a feeling without proper connection). The point here for our discussion is that when a patient descends deep into brainstem/first line, we see the terror and rage that we do not see when they relive on the limbic/feeling level alone. Here it is still anger and fear; it is only when we go deeper that it becomes primitive terror and rage. Patients again on that level are in the grips of terror, they may gasp and writhe, until they make the connection. It is origins and generating sources that may ultimately lead to cure.

Let me quickly add a point that may seem paradoxical: it is a pain that doesn’t hurt all that much. It is both a hurt and relief, at the same time. It is a great relief to be rid of something lurking in the background of our lives without cease, something that shapes our lives, interests, choices and reactions. We don’t know what’s there but it leaves in us a malaise and a chronic apprehension that is inexplicable. Because it is preverbal it takes time to learn what it is and what to do about it. We need to be careful about how deep to go and when. Going too deep abruptly can be dangerous, as in the mock primal practice of rebirthing. It is for this reason that our patients are never “led” or forced to those levels; it happens automatically as a result of the techniques we have learned over four decades.

As feelings mount, the reliving process may start with psychotic-like statements before patients are fully into the imprinted memory. As the terror rises toward conscious/awareness, they may have the thought, “I am going to die! They are trying to kill me.” And the cure involves reliving. Why? Because when the feeling rises fully it can connect to conscious/awareness. And connection is the sumnum bonum of cure. The pain and terror have finally been lived and exorcised. They are no longer a threat, which is why advanced patients no longer suffer anxiety attacks.

The goal of our therapy is to retrieve memory, not only of the scene or the place but of the feelings belonging to them; that is what has been repressed and held in storage, the pain and terror. When patients experience those feelings they become integrated. They are aware of the feelings even though they may not know exactly when it happened originally. It is the feeling that counts. Actually, I mean “the sensation.” Sensations pre-date feelings by millions of years. Previously their valence caused them to be repressed (otherwise there is overload), and thereby made them an alien force, unable to integrate with the rest of our system. When they are fully felt they are now part of us. It is how the first line connects. We connect, in short, on the level of the trauma and in that context only. And as the reliving goes on, there is a continuous drop in vital signs, arriving below baseline.

We must never skip steps, forcing someone to make something verbal when it lives on a different non-verbal level. There is also connection to the neo-cortex where we are aware of the feeling and how it drives us. We are consciously/aware of it all. Quite different from
awareness which is solely third-line. Too many therapies deal with awareness and not conscious/awareness. It is why insights make only superficial change.

Because the first line is the foundation of so much later behavior, when it is felt it provides so much insight into a wide variety of behavior. Those insights are based on deep structures but are eventually understood on the highest level.

We cannot make progress on the third-line cognitive level alone. We can become aware of why we act the way we do but nothing changes biologically; thus getting well only in our head. Our biology has been left out of the therapeutic equation. It is like being aware of a virus, which usually does not kill it. So again, connection means liberation of feelings in context. That last caveat, in context, is important. There are those who scream and write and cry out of context, as in an exercise. They make no profound change, but when the patient slowly descends to deep levels over time and reacts to the stimuli and events on that level with the neurological capabilities of that era, there is progress.

Consciousness means all levels of the brain working fluidly and in harmony. No levels are kept estranged from the others. We are “one” in the neuro-biologic sense of the term. And that should be the aim of serious psychotherapy—consciousness—not just awareness.

Some time ago there was a study of anxiety states that found alterations in the lymphocytes of the immune system as though the system was under attack; and it was by alien un-integrated forces. As the anxiety left there was a normalization of lymphocytes. It would seem that repressed feelings become an alien force, a menace that must be combated just like an invading virus. Is it any wonder that people with anxiety commonly suffer immune diseases?

The theory of three levels is illustrated by paranoia or bizarre ideation, often found in psychosis. What we have found is that, as feelings rise, there is sometimes paranoia: “I am going to die, or I am dying.” It is the direct analogue of the early imprint. It is not bizarre ideation when placed in context. It is a direct outgrowth of a memory of what happened to us. In paranoia it can become, “They are trying to kill me.” A drastically weakened gating system, as with the chronic use of marijuana, allows the deep feelings too facile access to higher levels where ideation and belief take over to block, bind and absorb the feeling. We often see paranoia in those who take hallucinogens. Feelings are unleashed while the defense system is weakened. Paranoia often ensues. We must think of it as third line defense. Under drugs such as LSD or marijuana, it is still the same memory imprint at base, only the cortical mind is forced into a more elaborate confection. Deep feelings and sensations have been prematurely unleashed. “I am dying” becomes “they want to kill me.” Often there is the leitmotif of death. This establishes for us the origins of some psychoses: the surging forward and upward of those deep imprints (where death was imminent), and the collapse of the gates. It forces the neo-cortex to concoct all sorts of strange notions to capture and encircle the feelings and give them some sort of rationale. So instead of feeling horrific pain and terror the cognitive brain concocts an elaborate fantasy/delusion. (Thomson, 2007, p. 85-113). The person can justify his terror – “they are out to get me; they want to kill me” – instead of feeling naked terror. To reiterate: there is an imprint of impending death, on the first line. It wends its way to the neo-cortex where it provokes a cognitive defense – “they want to kill me.” The imprint is real; the ideation is not. The treatment must involve the first line, not just the paranoid ideation. The kernel of this ideation is nearly always deep brain.

The pain and terror arise but before there is complete awareness and a full-blown attack there is strange ideation. The cortex is pushed to its limits; the last refuge of the defense system. We can understand more about killer rage: when there is trauma in the present the third line weakens and is infused with deep brain imprints. The person acts-out because there are no defenses, for the moment. And we know that the first line is involved because of the immense rage we see. In our patients the vital signs rise significantly when the first line imprint is approaching.

With connection, there is an actual living again of the repressed imprint and the pain/feeling becomes integrated; the vital signs fall in unison, not sporadically as happens in abreaction where there is no connection to the imprint, the generating source. This drop
informs us that a feeling in the session was complete. The danger is gone for the moment. The inner, imprinted danger has been faced and felt and integrated. Feelings, when inordinately painful and terror-ridden, are a permanent menace. The system is under attack by them, so when they begin to rise we hear “they are attacking me.” It is not “they.” It is the feelings.

Connection means full experience. It can be experienced uniquely on the non-verbal level (heart rate and blood pressure), or on the level of conscious/awareness where there is a cortical connection and complete understanding of the feeling. Feeling and integrating the causes of behavior prevents them from being acted out: “My mother always needed to know where I went so now I don’t use my turn signals because it is nobody’s business where I am going.” The act-out is what is generally known as neurotic behavior. The cure requires a complete reliving experience to origins, which means connection. Our therapeutic task is to help patients feel the pain/terror and bring it to full experience. We can experience terror without a label; but the aim is to diminish or eradicate repression which holds the feelings in place (see: “EGG study of amplitude and frequency in patients of a feeling therapy.” UCLA Brain Research Bulletin, Don Walter, 1973).

One way we control our hypotheses is to measure vital signs, which we do with every session. Feeling the terror physiologically can bring down the vital signs on its own. Over time there is also a significant drop in cortisol levels and enhanced natural killer cells. (see my book Primal Healing for discussion). The key metabolic changes also include a permanent one-degree lowering of body temperature; since body temperature is factor in our longevity and the work of our bodies it is an important index. It all means that we are getting to the pain and undoing repression.

2. RESONANCE

We have been investigating the process of resonance. The upper neocortical levels are intertwined neurologically, and evolve out of those lower levels so that when something adverse happens in the present it can resonate with or trigger related feelings on those deeper levels. In the same way that when a patient is on the first line in the Primal he can suddenly exclaim, “I feel like I am dying.” The feeling is of such a magnitude that it is suddenly impelled into the top level and is expressed verbally. One new patient in a session was approaching first line terrible pain, suddenly sat up and said, “God has just saved me. I have been saved.” The neo-cortex stepped in to absorb the overload and began its defense: “I am saved,” or rather, “I have developed an idea of being saved so that it can stop the pain.” The third line is simply doing its duty. The belief, “being saved,” happened automatically as feelings compelled the cortical gating system to begin its defense. Beliefs are not capricious but are in the natural order of things. It is not the therapeutic goal to change the ideas, but rather, to feel their underpinnings.

A wife leaving the home is often enough to cause rage in the husband. This is quite true if his parents divorced when he was a child and the mother left home with someone else. The resonance factor, set in motion by the divorce, can trigger off the original trauma, one’s mother running off with someone else. The old and new traumas combine to produce inordinate reactions. One can be engulfed by those feelings and through resonance and become enraged. In an experiential therapy the patient goes through those very same feelings, fury and killer rage. The difference is that he is in a safe environment where he can fully express himself and feel the old traumas that drive it. This is not a one-time affair; sessions go on many times, as the pain and terror cannot be relived all at once.

We have treated the results of re-birthers who have done just that, forced patients far beyond their capacity to feel. The damage is shattering (of defenses) and ineffable. They begin to have pre-psychotic ideas: “I am one with the cosmos. I feel the universe inside me,” etc. These same ideas sometimes extend to frank psychosis.
Once there is terror installed in the evolving fetus the genetic cells can change and become epigenetic. Those transformed cells are the carriers of terror. They drive neurotic behavior and all sorts of serious diseases including cancer (the cells that block cancer cells from developing are nearly always heavily methylated, indicating early trauma). The process of this imprinting is carried by methylating the cells; adding part of the methyl group of chemicals to the gene. The cells then carry the “brand,” perhaps for a lifetime. There is such a distance from the time of that imprint to terror of speaking in public at age twenty, that the source is not even considered. What has been imprinted is terror: terror of suffocation, strangling, deprived of oxygen and of being blocked from getting out. All of these are life-threatening and they remain in pristine form throughout our lives ready to surge forth. So there is inordinate anger when he tries to explain something to someone who does not understand; the feeling is, “I can’t get through – to you.” It has resonated with, “I cannot get through, get out, be free.” And that is entwined with a lack of oxygen; I will die if I stay here and cannot get out. So there is a great urgency to get through. First line is bursting through.

Thus, anxiety is terror emanating from the deep reaches of the neuraxis; more precisely, from the brainstem that controls digestion, breathing, elimination and other vital functions. Deep imprints can affect all of these processes and/or set up vulnerabilities to related disease, from diarrhea to pulmonary dysfunction. A first-line imprint evokes a first-line reaction, meaning midline reactions. That is how we know what level is likely involved in colitis. Since anxiety seems to work in reverse order with telomeres (those caps on the chromosomes that indicate how long we may live), it may be that experiencing imprints may lengthen life.

A heavy dose of anesthetics to the mother during the birth process can shut down the infant’s respiratory system and bring him near death. This is the time of rapid brain development where trauma can have long-lasting effects. Later on in adulthood, there can be a compulsion to try the door ten times a day to make sure the house is secure. This comes out of a basic feeling of being “unsafe.” It can drive the compulsion for a lifetime. Or consider the fear of failure, the feeling that so many patients have. Originally, it starts with fear of failing to make it out of the womb without great struggle when failing to get out successfully could have meant death. It is the struggle-and-fail syndrome that drives us to give up when faced with obstacles (Gluckman, 2005; Lewit, 2009).

Fear is the limbic portal of entry to earlier imprints. It opens the door to the terror down below, which is part of our primitive brain and predates our emotional brain by hundreds of millions of years. Terror is meant for radical and immediate action; a key survival function. When a carrying mother is seriously agitated, she is activating her baby, as fear becomes installed in him. When she drinks, uses tranquilizers or is seriously upset and fearful, it combines with the primitive earlier activation to produce a compounded response. When the mother’s emotional state goes on for an extended period of time it marks the genetic cells of the fetus and alters them, imprinting the terror response as an enduring legacy. And when our patients relive those early imprints the wrapping comes off the anxiety and it becomes the terror it was at the start; we see it now for what it is and was. It now has a context, an origin and a proper name. (Mykletun et al., 2009, p.118).

When feelings burst through to conscious/awareness later in life we call it panic or an anxiety attack. It is not; it is the same pure terror that was imprinted perhaps decades earlier, now filtered through the gates. It may arrive in disguised form, a phobia or compulsion, but at base it is still that terror. When the terror is felt and experienced neurophysiologically, the phobias often fall away as does migraine. We lower hypertension on average 24 points after one year of therapy. It is also associated with the lowering of cortisol levels. (Goldman, 1998, p. 936-940). We are taking the pressure out of the system and normalizing the person.

We need to understand that the first line is the basic foundation of our system. It shapes the second-line feeling system, and ultimately can distort the third-line ideational one. To solve problems on higher levels we need to return to the basic foundation that formed and helped de-route them.
3. ON RELIVING

The question is often raised, can we relive events in the womb while we were being carried? When a patient with leaky gates (the gates that separate levels of consciousness) starts to relive a trauma about his infancy during a session, there is sometimes a breakthrough of birth events. The trauma, say, of diminished oxygen where the mother was given heavy anesthetics, intrudes; the patient will gag and feel suffocated, unable to catch her breath. So in the midst of experiencing how it felt to be spanked or criticized as a four year old, there is suddenly a suffocation; the patient is literally having a near-death experience. It is called first-line intrusion. We often see this in very disturbed people or in drugs addicts. There are preverbal memories that can intrude and elevate key vital signs. The exaggerated reactions tell us that there are possibly early imprints that drive and compel the reaction.

In therapy, the descent to the deep brain is slow, methodical and evolutionary; it is evolution in reverse. After one year of therapy there is a sustained drop in blood pressure, heart rate and body temperature. The key word is “sustained.” It is not palliation; it is more substantial (Hoffman, 1981). We are governed by the rules of evolution and biology.

4. MORE ON RELIVING

One way we can be sure about reliving on the first-line is the patient loses all his words; he cannot speak nor can he cry. He is on a most primitive level of nervous development, long before there is the capacity for words and ideas. If the patient ever says a word during her birth Primal we know it is a false experience. It has never happened when the therapy is done properly. We see this in those who come to us from those who claim to be doing our therapy. They have learned to scream and pound the walls and say, “I hate you, daddy.” Newborns do not have words.

It was in 1965 that Melzack and Wall described the gating process (previously cited). It offered a new heuristic for the control of pain, and pointed the way for how we modulate pain. When there is much abuse, violence and neglect in a childhood home, the gates suffer. They no longer have the chemical wherewithal to combat the imprint of pain.

When gates are weakened the energy of hidden feelings can approach conscious awareness. This can leave us anxious and agitated and still unaware of what is happening.

Leaky gates allow those early imprinted sensations to rise, triggered off by something in the present (divorce or loss of job) that evokes the original generating source, and the same feeling –hopelessness. While we experience something in the present, an old feeling from childhood can break through to upset us. There have been hundreds of studies over the last few years pointing to womb-life trauma and its later effects on our health and personality. (see again: The Fetal Matrix, cited elsewhere). The earlier that trauma the more widespread and deleterious the effects, not excluding cancer and Alzheimer’s disease.

(We are planning a research project on Alzheimer’s using the questionnaire found in the back of my Life Before Birth. Preliminary evidence, unconfirmed, points to a connection between the disease and terrible trauma during womb-life.)

At the end of a session when the patient has relived oxygen deprivation, he may begin rapid breathing to compensate for the lack of oxygen he experienced during the session. Or more likely, when a patient is in full first-line suffocation he may begin what I call it locomotive breathing, raspy and hoarse, rapid as though the patient is making up for the event by gasping for air. (We have done research on this in 1992, together with the Pulmonary Laboratory of UCLA. Due to a change in director the details of the research has been lost. It has been filmed.)
Heavy breathing can go on for many minutes, and then relaxation. It may take many sessions for the cause to be comprehensible. Though this heavy breathing goes on for up to twenty minutes there never is any hyperventilation. We have done experiments when the patient is not in a memory and after three minutes she gets dizzy and feels like she will faint. Her hands get cramped and she loses some coordination. It happens systematically to those who attempt to go back to the past without being totally in the memory.

To underscore: being in a past feeling is a total biologic state which permits deep breathing for a long period. The patient is engulfed by the memory of depleted oxygen and at that time needed oxygen. It is one of many checks we have on the Primal state. Patients are indeed in the past neuro-physiologically. We also verify whether the vital signs during a session are coordinated as they move up and down or do they do so in sporadic fashion. A real reliving means coordinated vital signs. That is why a patient on the verge of high valence feeling has uniformly high vital signs: brainwaves, body temperature, blood pressure and heart rate.

We watch for first-line intrusion because it means a mélange of levels that prevents integration of a single feeling on a specific level. With this kind of deep Primal we can see apnea at the end that can go on for a full minute; no breathing whatsoever. We can only hypothesize that it is a last effort to conserve oxygen. In the session when vital signs drop after reliving a trauma it indicates that integration is happening. There is no more anoxic feelings nor death-approaching fears; no more panic.

In some respects a Primal seems to be a conscious-coma, except it is also a partially conscious one. The patient for the time is back there, slightly aware of the present; it is a true reliving. There is still a peripheral awareness of the present, but when back there she can cry like an infant, which she can never duplicate after the session. It should read, “cry as the infant.” It is the infant crying.

When the two sides of the brain are better connected in a Primal session, there is a relaxation that endures. Feeling connects them, while painful unfelt feelings keep them apart. There seems to be two sorts of connection and integration: right to left (horizontal) and bottom to top (vertical). When that happens we begin to have normalization. Erik Hoffman and a colleague from Rutgers University (L. Goldstein), found that the brains or our patients seemed to equalize after one year of therapy, a change of power between anterior and posterior sections of the brain as well as between the right and left hemispheres. (Hoffman, 1981).

Through the process of resonance the early pain is dredged up because it is in some way related to the current feelings. It may have something to do with identical or similar frequencies. The work of the late Mirecea Steriade (1996) (Bucharest) helps explain the possible process through parallel oscillations of neurons. The early memory that is “resonated” can take the form of hopelessness or helplessness when the current situation leaves the person feeling both feelings (hopeless and helpless). When the clerk at the Department of Motor Vehicles keeps blocking a patient’s attempt to explain something and she says, “sorry, there is nothing I can do.” Rage may set in, controlled by the neo-cortex. Ostensibly, it is a Primal about the DMV, where hopelessness is felt. This may evoke the very early hopelessness felt when trying to get born and being suffocated with drugs, the truly Primal hopelessness. Years later when trying to get through to someone, in vain, that deep hopelessness sets in and there may be depression as one result. The feeling is “I can’t get through---to them, and there is nothing I can do.”

The first part – “can’t get through” – expresses the early pain/ imprint perfectly. We note how the third-line accommodates and rationalizes the lower levels. The imprinted feeling, “cannot get through or get out” remains in pristine form throughout our lives. So long as the feeling remains unlived and therefore not experienced, it will be acted out. So long as buried feelings remain compartmentalized and an alien force the person is forced to act-out. Here is where so much trouble lies. Someone who could not trust her father who was seductive with her, may be suspicious of her boyfriend and his motives. It is the first line that drives the act-
out of impatience, impulsiveness, screaming episodes, etc. It is usually the second line limbic input that gives direction to the feeling.

Those who relive hopelessness over time in therapy undo their depression. This is discussed in my work (Janov, 2007). It is resonance that permits the patient to go from one level and then descend to another enabling incredibly strong reactions. It always seems like so incomprehensible when a child is very disturbed, even though she had good parents and a normal childhood. All that was left out was the key period of their lives which was so important, gestation and birth. Here is where we see extreme reactions that point to deep levels of pain. It is measureable. Generally, the higher the valence the more harmful the imprint. When a depressed enters therapy in a cognitive clinic she can be labeled “endogenous depression,” when it simply derives from an imprint well sequestered.

The way we relive womb-life can only be within the possibilities of what the first line can do; that is, relive the physiologic effects with no feelings possible, as yet. On that level we can’t shout nor cry/sob. Feelings arrive later in phylogeny and ontogeny. So when we have inordinate anxiety while we are reliving something much later in our childhood, it signifies first-line breaking through; an ancient brain is informing a higher brain of its pain. The first line, in brief, can only provide simply biologic reactions of heart, blood pressure, body temperature, as well as changes in hormone output (our beginning patients who were high in stress hormone levels, cortisol, became normal after one year of our therapy. (see: Hoffman reference). We cannot expect the first line to speak. It “speaks” already, and we are learning that language every day. For example, there is a certain foot position in reliving of birth; when not there the Primal is suspect. When we look at a chart of the birth process we always see that foot position (except in breech birth). The face sometimes takes on a fetal mien. It is an ensemble of physical behaviors that inform us as much as words. The behavior is unique to the first line so that we must not expect more mature behavior; and of course, even in infancy, we do not expect to see adult words such as “justification” or “sporadic.” It all betrays the level of consciousness operating at the time.

The lower level intrusion gives the Primal much more force, inordinately so, more than we can expect when the patient relives something when she was eight years old, for example. And when she is measured with a rectal thermometer (thermistor) during the session we will see significant spikes in measurements. This happens when the current feeling has a strong first-line componet: This can raise body temperature two degrees.

We often see intrusion in pre-psychotics where there is nearly always a first-line aspect, barely repressed. And for this they often need painkillers or tranquilizers to repress the force. This is required only for a time. Medication is the not the aim of therapy; it is a temporary intervention to allow the patient to have a single feeling to deal with, without inundation. The reason we use medication on rare occasions is because it helps separate the levels for a moment so that one level does not trespass on another. Dampening pain on one level with medication informs us of how each level, although interconnected, has its own independent existence and its own pain. There are specific first line blockers such as Alprazolam (Xanax), that hold first line in place, while other pain medications cannot. Certain medications target first line while others are more limbic directed, still others are cortex oriented. Xanax is not sold as a first-line blocker; it is promoted by the pharmaceutical house as anti anxiety. And that translates to us as a first-line blocker.

Patients are often not aware afterward that they relived on the level of the first line. It is only after many relivings that it becomes apparent. The fetus certainly is not aware of where he is and what his surroundings are, yet he responds to it. In the session he is again responding in the same way as originally, possibly with the same vital sign changes. We have noticed that when a patient is reliving a specific feeling time and again there is almost an identical vital signs reading.

When the mother smokes it might lead to an offspring who holds her breath under stress. The original trauma has set up a prototypic defense apparatus. She is again conserving oxygen when stressed. When she is upset she may systematically hold her breath. It is again the Primal/primordial reaction to suffocation. Migraines can also be set off as a response to
reduced oxygen first in the room, then in the womb. Vasoconstriction is one of many biologic means to conserve oxygen.

The body’s defenses are rather exquisite. Patients sometimes enter the session in a full-blown panic attack; they are breathless with the heart pounding severely. They will lie down and go straight to the first line. When the session is over they usually know what brought it on and what to do about it. It is a relief to know that one no longer has to suffer in silence – hopeless. There is something that one can do, and that is the message of this article; to know there is a possible answer.

Prolonged anxiety may well cause a premature death, and in addition will damage the cognitive brain and diminish its thinking/reflective capacity later in life. What it also does early on is input so much neural information as to keep the person from focusing on one thing for any length of time. There is so much stimulation from the imprint inside that there is little chance of allowing serious input from outside.

I use the sequence of my patients in their reliving as an example. First they feel amorphous pain and suffering, then they attach a scene to it such as “they don’t love me,” (furious), “You bastards, why don’t you love me?!” Then the patient begs, “Please love me.” And finally, “It is all hopeless.” It reminds us of the gunman who seems to follow the same sequence. Often the wife has left and taken the kids who gave him love. He is furious and wants to kill (in Primal) but actually does kill in real life. Then there is the ultimate hopelessness and giving up (in therapy the pain/truth is finally felt and liberates the patient from the importuning imprint) but in outside life the gunman stops at hopelessness and kills himself. He has gotten rid of his anger but there is nothing left, nowhere to go with his feelings and no resolution. Life has lost its meaning; stuck in the agony, no way to feel better, no more chance for love, no reason to go on living.

5. ANGER AND RAGE

Here is how resonance works in the domain of anger. Something in the present makes someone very angry; his wife is divorcing him and trying to keep the kids. Money is running out and she still wants more. She refuses to see or talk to him. She turns the family against him. He has been let go at his job due to injuries and has no prospects for a new job. All looks bleak and there is no alternative. All these are assaults on defenses. There is only so much that can be absorbed and integrated. And all this rests on a foundation already weakened throughout childhood, as in the case of a mother who leaves home for someone else. Defenses weaken so much that there is no barrier holding back deeper compounded pain. The person loses control and the consequences can be serious. Clinically, the lower levels burst through to cortical levels so that perspective and critical judgment disappear; he is out of control because that is the central function of the third line which is no longer operational.

Here the problem is on the feeling level where there are powerful emotions. Clearly, the treatment cannot be focused solely on cortical level. What has happened is resonance. The current situation with the wife resonates with deeper anger which ultimately turns to rage and fury. Thus, the third-line gives way to the first-line reptilian brain where killer feelings reside. And for that moment the third-line, inhibitory brain is replaced by the instinctive, primitive brain, and there might be murder. The deepest brain level becomes the highest operating one, temporarily. This may only last minutes. Once the rage is expressed the pain level diminishes and some of the third-line thinking, reflective brain returns to function. And the killer can now say, “I know what I did.” At the moment of crisis he did not know what he was doing; his rage took over and he came under the control of the reptilian brain.

That is an extreme example, yet based on forty seven years of clinical practice. With less imprinted pain, resonance can also simply lead to impulsive behavior where someone acts-out without thinking. Inhibitory and delaying cognitive processes give way to primitive impulses, and we get what I saw recently in therapy, a well-known football player who had exhibited himself in public. He needed to even more prove he was a man. The origins here
had two levels active, childhood trauma where he was denigrated as a sissy by a macho father, and deeper pain from a mother who drank during pregnancy; only one cocktail at night but it was devastating. Every time he asked for help his father would say, “Are you so helpless you can’t do anything for yourself?” The whole affair was channeled into the sexual realm. Needless to say, he masturbated during his act-out and finally found relief. Instead he needed to beg: “Love me, daddy, hold me, cherish me, don’t put me down.” This finally produced definitive relief.

I have seen rage over and over again when very disturbed patients begin to relive on the emotional, feeling level and suddenly are impacted by the lower levels. They begin to pound the mattress and the padded walls with an enormous fury; they can scream for thirty minutes. In therapy, they can direct the rage, connect with it. The patient will not be overwhelmed by it. Therapy is a controlled situation and is not acted out. It becomes acted out when the person has no idea that there are feelings deep in the unconscious, and is helpless to control them. His unconscious has taken over. And he may kill. Rage lies on the same level as terror; they are our primordial ancestors, both survival mechanisms. If we are going to fight for our life we need to first have fear and then get angry — furious.

Those who are about to kill are often engulfed by paranoia. Paranoia is often a sign of deep feelings on the rise that impel ideas: “They want to kill me.” In any case, these ideas are fore-runners of first-line feelings, which have been triggered and are on the rise; but the killer never drops into those memories/feelings. For that he would need professional help. He kills instead. He acts-out those feelings. And he does so because most of his life is loveless and traumatic: father leaving home, mother an alcoholic. These are the daily assaults in childhood that weaken the defense system. They become compounded so that serious mental illness ensures.

Anti-psychotic medication helps dampen the lowest brain levels from reacting. Medication holds down response. It does this by enhancing the top level so that it is more active and effective; and at the same time there may be inhibitory medications in it that block the lower level pain; thus, we get a more active cortex and a less active brainstem and limbic/feeling brain. Often the content of this medication includes chemicals that we should produce ourselves. But we don’t because all that early trauma has exhausted supplies. We cannot make enough to blanket the pain. So when our inner pharmacy cannot do the job we need help from the pharmacy around the corner. We can call it anti-psychotic medicine but all it is doing is making up for what we can no longer manufacture ourselves. It is a first-line blocker.

The lesson we can take from this is that when deprivation and severe trauma exists while we are being carried in the womb and at birth, the first-line defenses are already in a weakened state. We are then born damaged, which may not show up for years.

In the case of rage, the infant may have had uncontrolled temper tantrums. These are the precursors. We can go a long way to avoid murderous rage by making sure there is as little trauma as possible when we live in the womb. No drinking and drug-taking by the mother. No fights with her husband. No crazy diets while carrying. What we can do to change society and escape harm is to change our birth practices. No more heavy drugs given to the mother at birth. Making sure the newborn is held and caressed right after birth. Much of this is discussed in my book, Imprints. Gestation is our real childhood. What happens during those months affects us for a life-time, determines how we behave and what diseases we will have, and ultimately how long we live.

So long as feelings remain alienated, we may shorten our lives. Our hypothesis is that Primals keep telomeres (one index of longevity) from premature shortening. Generally, the longer the telomere the longer we may expect to live. But that is a variable that remains to be measured.
6. ON LEVELS OF MEMORY

Too often we consider memory as something we can remember verbally. But there are several kinds of memory; each level of consciousness remembers in its own way. The emotional system remembers through feelings. Something makes us cry and we have no idea why. We remember on non-verbal levels in non-verbal ways and relive in that way.

Epileptic seizures can be another form of memory. As patients relive first-line we see that it is often an epileptic equivalent. Later in therapy they will have first-line Primals in lieu of a seizure. We have had success with epilepsy because we remove a level of pain that sometimes makes the seizure manifest.

There are third-line approaches to control first-line symptoms; avoiding enclosed places, a "doppelganger" of an oxygen-deprived gestational life. Enclosed spaces, for those who have that imprint, are avoided in order not to trigger off a panic attack. It can be caused by a mother who could not open up easily for the birth of the baby or a mother who has been drugged by the doctor at birth. It is not the enclosed space that is the danger; it is the memory of what it provokes or resonates with. The level that it provokes can be deep. So even a room with no open windows can set off anxiety. ("I can’t get out.") A Primal can make it conscious but even when unconscious, it is still an active memory. It still agitates. We can help this by opening windows, or better, by getting to the bottom of it where the person can feel enclosed and imprisoned. In our work we make all of those levels, over time, into consciously/ aware experiences; not mainly verbal experiences, but conscious ones. We never try to transmute a non-verbal memory into something verbal and/ or intellectual. In conventional therapy, “tell me how you feel,” can be a deceptive technique that confuses levels. It uses the third line to try to evoke the second; but one level of brain tissue cannot do the work of another. The third line is a specialist in ideas and philosophies. It can meticulously analyze. It is a level of precision but not predominantly emotional.

7. THE CRITICAL PERIOD

I have not mentioned the critical period but the key imprint occurs during the time period when specific needs must be met. When not met at this time, the imprint becomes largely irreversible. (We can often reverse the imprint because patients address and live it again.) When need is at its zenith, it demands fulfillment; if not, there is pain. And the pain gets more forceful the earlier the need. We need a calm womb-life. We need a baby immediately in contact with the mother after birth. If he is not touched for eight weeks after birth (the mother is sick) there is already great harm as the critical period for fulfillment is passed. We can imagine what harm has been done to orphaned babies. Yes, touch is helpful after the critical period but the imprint of deprivation may already have been set down in the system.

During womb-life depression or chronic anxiety in the mother can be deleterious. She must not diet to keep trim and deprive the baby of nourishment. When she does there may be an eating disorder that lasts a lifetime. If there is a memory of starvation in the womb then when the offspring is hungry later on she overeats; she eats for now and for the starvation experience which gives it a great and forceful compulsion. This is one of many checks in our clinical work; the force of the compulsion, whether of food or drugs. It speaks of early severe deprivation of need. Here again, there is a merger of levels and subsequent addiction. As always, there are many other factors. I only ask that we consider the factors I have outlined (Meaney & Seckl, 2008). First-line driven behavior is often forceful and out of control as it provokes the third line to control, which it is not often up to the task.

In a recent study, Justin Feinstein at the University of Iowa City looked at subjects who had a damaged amygdala, the hub of the emotional system. (Feinstein, 2013) They did not have normal fear responses; that is, they failed to feel fear when they should have. But if oxygen supplies were lowered and carbon dioxide supplies were increased, mimicking suffocation (increasing acidity of the blood), there were panic attacks. The causes? Certainly
not from the usual emotional structures. Researchers believe it includes the brainstem! Because the lowering of oxygen supplies and increasing of carbon dioxide provoked the lower structures to sense the danger and react appropriately. Very much like what happens to a fetus when the mother smokes during pregnancy and produces those same effects.

Fear and terror are two different reactions involving different brain systems emanating from structures hundreds of millions of years apart in evolution, as is anger and rage. However the emotional reactions have some similarities which allows resonance; that is, enough sustained fear can move deep in the brain and trigger off those primitive panic/terror responses that I call first-line. It is not ordinary fear; it means a life-endangering cause and that comes from our time in the womb and at birth when lowered oxygen was life-endangering and panic inducing. If all this is ignored there can be no cure because cure involves the generating source of behavior.

It is interesting that suffocation has such a great terror reaction associated with it. In the panic attack there is often a feeling of suffocation, one cannot catch one's breath, the heart beating so fast that it is about to jump out of the chest. And these breathing problems are again brainstem originated (included the medulla of the brainstem). It is an ensemble of reactions originating deep down that later on set the stage for many kinds of pulmonary problems, asthma, shallow breathing and other malfunctions.

It is important to treat the nightmare, even to drug or medicate it but we cannot medicate/eradicate an imprint; that remains to go on causing damage. So nightmares, panic attacks, breathing problems, pulmonary dysfunction are all part of an ensemble, a gestalt, if you will, that must be considered as one problem, not many problems. There are many symptoms, each symptom must be treated until we arrive at the generating source where it is all treated at once. The imprint that is immutable. Now we know what Freud was getting at by the “id.”

When we note all of the disparate aspects of a panic attack we see that physiologic memory comes up intact with the whole panoply of related feelings. There is the breathing, the circulatory system, the musculature; all respond to a single imprint. —There is the racing heart, high blood pressure, breathing problems, shakes and dizziness.

There is often too much terror to feel all at once and integrate it. That is why it needs to be revisited time and again in slow, ordered fashion to prevent an overload.

Clearly it is so remote an experience that it can be experienced over time but not immediately understood for what it is. We can experience it long before we understand it; experiencing it is crucial for integration. The heart has to race again while the body temp must again rise as it did originally. And as I mentioned, the physiologic signs in a Primal are the exact reactions originally; the same heart rate and body temperature. It is an exact reliving. The imprint does not change nor does the behavior based on it. Understanding is the last evolutionary step, when the feeling is on the first step. The re-birthers treat the tail while the cognitivists treat the head; both miss the rest of us. The human part.

Non-verbal experiences can be relived and experienced on their own terms and in their own way, and can be integrated, nevertheless. There are times when a patient can remember when his dog died after being hit by a car. That is top level cortical recall. What needs to be experienced and expressed is the repressed emotional aspect of the experience. The pain needs to be liberated and finally felt. It too needs to express how it feels.

Liberation is the goal. Not as an exercise or a technique, but always within a context. The urgency of the recognition of deep brain levels is brought home in a recent article by A. R. Brunoni and colleagues, “The Sertraline Vs. Electrical Current Therapy for Treating Depression.” (Brunoni, Valiengo, Baccaro, & et al. 2013) By stimulating the brain with low-level electrical stimulation (trans-direct current stimulation), they claim to have had success with depression during tests with 120 subjects. The patients are under anesthesia for twenty to thirty minutes, while undergoing continuous stimulation. It is a turn on ECT but much milder. The results seem to work as well as low doses of sertraline, commercially known as Zoloft. So the conclusion is that the procedure "could be used to avoid drug treatment."
There is no discussion of cause here. The assumption is that we have only two choices, none that includes feeling.

To reiterate: because it is now established that lowered oxygen levels in the fetus creates panic in him, it should be clear that a carrying mother who takes drugs is damaging the baby severely. Can he really feel terror? Anand did an amniocentesis on fetuses and found as the probe invaded fetal space all of his stress hormones rose; he also grimaced and showed signs of distress. (Anand, 2007)

We have successfully treated panic attacks and uncontrolled rage because we address the first line. It is not a mystery; it just belongs to an ancient brain system that we have ignored for too long. If we want to help those in danger of acting out and to help those who suffer panic we must travel to a life hundreds of millions of years ago in phylogenetic history, deep in the brain in our personal history, to find our answers. And they are there.

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