Working with Pre- and Perinatal Material in Psychotherapy

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Full Text: Headnote ABSTRACT: This paper is an attempt at an historical survey of psychotherapies that have successfully accessed pre- and perinatal memories. A variety of ways in which psychotherapists work with material that is felt by the therapist or the client to be linked to pre- or perinatal life are discussed, and certain desirable criteria for the practice of humanistic and rational pre- and perinatal psychotherapy are suggested. It is proposed that the systematic study of material that emerges in the course of psychotherapy is facilitated by identifying it with a specific stage of pre- or perinatal development. INTRODUCTION I would like to discuss the various approaches to working with material that emerges in the course of psychotherapy and that is felt either by the client or the therapist to be related to pre- or perinatal life. By the word "material" I denote the whole gamut of verbal and nonverbal communications between a client and their therapist as manifested in dreams, slips of the tongue, behavior, symptoms, interpersonal difficulties, transference phenomena, sudden body sensations such as pain, an image or a word that spontaneously jumps into the client's mind, overreactions to situations or people, etc. The major premise of all insight-oriented therapies is that the resolution of unconscious conflicts leads to improved mental health and the disappearance of symptoms. A significant part of this process of "making the unconscious conscious"-as Freud put it almost a hundred years ago-involves the recovery of traumatic events. Until the advent of pre- and perinatal psychology, therapists who engaged in regressive work never, with some notable exceptions, explored their clients' lives before age two. Today, a growing number of therapists do exactly that. These therapists accept the validity of concepts such as cellular memory and the possibility of genuine memories formed prior to birth. I personally believe that two separate but complimentary systems serve our memory. One is cerebral memory, which depends for its functioning on the establishment of mature neurological networks that comprise the central nervous system. This system is operative by the end of the second trimester, i.e., about six months post conception age. The other system consists of cellular memory, which is based on a holographic model where each cell knows what every other cell knows but also carries some additional information specific to that cell. Cellular memory operates in the sperm, the ovum, and their subsequent union and development. This bi-polar model of memory explains the hitherto mysterious existence of validated memories from before the third trimester, past lives therapy, the Jungian concept of the collective unconscious, as well as reports of people declared clinically dead who describe accurately what transpired while they were "gone." Therapists who subscribe to the new pre- and perinatal orientation are willing and eager to take their clients on a journey to the dark wonderland of womb life in an attempt to reach and resolve the original or primal traumas that, in conjunction with subsequent traumas, led to aberrant development of the client's personality. I think it is important to realize that by rolling back the conventionally held age barrier to the recovery of memories, we and those who have preceded us are responsible for initiating a major revolution in psychology. However, in the process of supplanting the old order we run the risk of establishing a new and narrow orthodoxy of our own. In the past, psychoanalytic colleagues would drive me to distraction with formula interpretations such as "anything longer than it is wide is a phallic symbol" or "anything that provides nourishment stands for the maternal breast." Today, listening to some of my pre- and perinatal colleagues, sometimes I am equally disturbed by their interpretations of a patient's material. For example, not every patient who dreams of descending a staircase, being trapped in a sewer, or trying to open a locked door is reliving his birth. Not every memory of conversations overheard between parents while the patient was still in the womb is authentic. Therefore, we need to ask ourselves: How do we apply our new understanding of the mental and

emotional life of the unborn child in a rational and responsible way to the healing of pre- and perinatal wounds in children and adults? Unfortunately, we lack "scientific" guidelines for establishing a psychotherapeutic intervention as being either correct or incorrect. One of the objectives I hope to accomplish in the course of this discussion is to arrive at some criteria that would define sound psychotherapy. Let me give you some examples of what I consider unsound psychotherapy. One of my patients told me that her former psychiatrist interpreted every dream of hers that dealt with her father, mother or husband as her wishing these people dead so that she could be alone and suffer just as she did when she was born and placed in an incubator. So what's wrong with that kind of interpretation? Mostly, that it does not in any way relate to the patient's own mental life. She did not wish her parents or husband dead. She had absolutely no desire to return to the isolation of the incubator. Even if in some weird unconscious way she did, and this is the second problem with an instant prefabricated interpretation, she would not have benefited from it because she was not ready to consider it. The therapist's comments were rejected by the patient intellectually, though emotionally they caused her a lot of anxiety. In this particular case, the patient got progressively worse. Her therapist told her that she needed to get worse before she could get better. You can see here the workings of a closed system that can gradually grind down any resistance. I would like to examine another example of a therapeutic interaction that I consider dangerous to health. Though the focus is not on pre- and perinatal material, I refer to it here because I consider it an excellent example of ideologically driven psychotherapy. By this I mean that the psychiatrist has some predetermined and strongly held notions about psychotherapy and whatever the patient says or does is fitted into this ideological grid regardless of the patient's own reality. My example is taken from what Wilfred Bion1 (1955), highly regarded British psychoanalyst, calls the "essentials" of two sessions with a schizophrenic patient who had been five years in analysis with him. As you read some excerpts from Bion's and his patient's interchanges, keep in mind that Bion believed that "interpretations should be in language that is simple, exact and mature." Patient: I picked a tiny piece of skin from my face and feel quite empty. Analyst: The tiny piece of skin is your penis, which you have torn out, and all your insides have come with it. Patient: I do not understand . . . penis . . . only syllables and now it has no meaning. In the next session the exchange went as follows: Patient: I cannot find any interesting food. Analyst: You feel it all has been eaten up. Patient: I do not feel able to buy any new clothes and my socks are a mass of holes. Analyst: By picking out the tiny piece of skin yesterday you injured yourself so badly you cannot even buy clothes; you are empty and have nothing to buy them with. Patient: Although they are full of holes they constrict my foot. Analyst: Not only did you tear out your own penis but also mine. So today there is no interesting food-only a hole, a sock. But even this sock is made of a mass of holes, all of which you made and which have joined together to constrict, or swallow and injure your foot. This and subsequent sessions confirmed to Bion that the patient felt he had eaten Bion's penis, leaving a persecuting hole. Ten days later, a tear welled from the patient's eye and he said with a mixture of despair and reproach, "Tears come from my ears now." No wonder tears were coming from his ears after hearing these "simple, exact and mature interpretations", day after day, week after week, month after month, year after year. I do not know what the patient means when he says that he picked a tiny piece of skin from his face and feels empty. Bion seems to think that he does. His suggestion, at any rate, is that the patient has torn out his penis and his insides have gone with it. I am not surprised that the word penis in such circumstances means no more to the patient than the syllables that comprise it, or a sock full of holes which constrict his feet. Nothing in the statement that he can find no interesting food suggests that he feels it has all been eaten up. It is difficult to imagine what the patient could say that could tell Bion anything he does not think he knows, or which could possibly reveal to Bion that his constructions could be wrong, or that his interpretations reduce any sense to total nonsense. Change the way of listening to these exchanges, and the analyst's remarks seem to be coming out of the mouth of someone who could well be diagnosed as an extremely disturbed paranoid schizophrenic, hounding one of his persecuting victims. Honors for craziness are evenly divided. I think we can all agree that the exchanges just described represent a very pernicious form of therapy. There is really no difference between these "dialogues"

and indoctrination or brainwashing in totalitarian countries. Bion's patient picks his skin, cannot find any interesting food, his socks are full of holes, he feels empty and tears come from his ears. Is this man depressed or what? If the psychiatrist responded to his pain with appropriate verbal or nonverbal communication, the patient could begin to gain some self-esteem and ego strength and gradually work through his pain. As it stands he only feels cut off and crazy. In contrast to Bion's interrogations, it is of interest to read another well-known British psychiatrist, D.W. Winnicott.2 I wish to describe an episode in the analysis of an apparently defective boy whose defect was probably secondary to early psychosis, and not due to brain limitations. This boy, who was then five, spent a month or two of his analysis testing out my ability to accept his approaches without demanding anything, and actively to adapt to his needs in a way that his mother could not do. He repeatedly came towards me and went away again, testing my ability to accept him. Eventually he came to sit on my lap. No words were spoken at all for the whole of this period. The further development of his relation to me took the following unexpected form. He would get inside my coat and turn upside down and slide down to the ground between my legs; this he repeated over and over again. When he had thoroughly established this procedure which seemed to follow his decision that I could be used as the mother that he needed, he would get up from the floor and demand honey. I procured honey (and later cod-liver oil and malt, which was easier to get during the war) and he would often scoop out as much as half a pound and eat it immediately with great relish. This was the beginning of a tremendous phase of oral activity with excessive salivation. After this experience I was prepared to believe that memory traces of birth can persist. Of course the same thing in play has turned up in many analyses and on still more occasions in the play of normal children and in one's own play as a child. Winnicott's therapy strikes me as ego-enhancing. He follows the patient's lead instead of imposing his own ideas on him while providing a safe and accepting environment in which the patient can regress and attempt to finish the unfinished business of the past. THE GESTATIONAL MODEL There are several ways in which one can systematically study material that emerges in the course of psychotherapy. Because our focus is on pre- and perinatal life, I propose to use a Gestational Model in which I arbitrarily divide the first phase of life into six stages as follows: A. Primary Germ Cell Stage B. Conception Stage C. Oviduct Stage D. Implantation Stage E. Uterine Stage F. Labour and Birth Stage I shall discuss each stage in terms of the major contributors to our knowledge of it, the symbolic expression in sensations, images, symptoms, etc. peculiar to that stage of development, and my own theoretical orientation and clinical approach. Primary Germ Cell Stage I think that as we explore new frontiers in psychology it is incumbent upon us to be aware of the people who preceded us on this journey. I do this not only to honor them but also to save us the trouble of reinventing the wheel. During the past 100 years a large number of psychoanalysts have made important contributions to the study of pre- and perinatal psychology. The very first paper that ever dealt with the psychology of conception was written by a virtually unknown analyst, Sabina Spielrein.3 It was called "Destruction as a Cause of Coming into Being" and was delivered in Vienna in 1912 to the small circle of analysts around Freud. It is a paper that was at least 50 years ahead of its time, and I think that even today it could be studied to advantage. Spielrein argues that in the fusion of the two gametes both destruction and new creation occur. The male segment becomes dissolved in the female while the female segment becomes disorganized and takes on a new shape through the alien intruder. The change in structure hits the whole organism. Destruction and reconstruction, which ordinarily happen slowly and cyclically, here happen abruptly. Spielrein thinks that it would be unlikely if the individual did not at least sense these destructive and reconstructive processes. The person who first attempted to systematically chart the unknown territory of intrauterine life was the brilliant Scottish psychiatrist R-D. Laing. In his groundbreaking book "The Facts of Life,"4 Laing writes: "It seems to me credible . . . that all our experience in our life cycle from cell one is absorbed and stored from the beginning, perhaps especially in the beginning. How that may happen I do not know. How can one generate the billions of cells that I now am? We are impossible but for the fact that we are."5 Later, he asserts: "It is at least conceivable to me that myths, legends, stories, dreams, fantasies, and conduct may contain strong reverberations of our uterine experience."6 The

connection between prenatal and perinatal experiences and myths, fairy tales and art expression has been explored extensively by Lloyd DeMause,7 Michael Irving,8 Thomas Verny,9 and Ludwig Janus,10 and due to the limitations of space will not be discussed here. Here are two examples of material that emerged in psychotherapy in my own practice that seem to go back to the primary germ cell. A thirty-year-old woman relates a dream. "I dreamt I was the earth. I was warm, rich soil and very fecund. I asked myself in the dream if I was mother earth or the Earth Mother. The seeds were planted and only waiting for the warm rain to grow. When I woke up I was convinced I had just had an ovulation dream. Checking my calendar I found that it was indeed the time of ovulation." A 25-year-old man in a primal group finds himself getting smaller and smaller. He describes himself as if he were falling down a funnel. Then he does not talk for a long time. When he "comes out" of the experience he says: "I seemed to be for a time both ovum and sperm. There was a feeling of uncertainty between us. Did we want each other? Suddenly I identified with the sperm and I was making undeniable efforts to penetrate the ovum which did not want me. I was kicking and wriggling like mad. Then I was home. It didn't feel good. It didn't have the quality of unity or wholeness I would have expected." In the past this man always chose women who in the long run rejected him. Following this particular insight, which he gained totally on his own, his relationships with women gradually improved until three years later he finally found a woman whom he married and as far as I know still lives with. Graham Farrant9 has spoken eloquently at previous PPPANA congresses on cellular consciousness. He has shared his own experiences and those of his patients from the time just before fertilization to birth. At the Atlanta Congress (1991) he discussed the mutual attraction between the ovum and one particular sperm that the ovum seems to select from the ones courting it. His concepts are based not only on clinical case material but also on detailed photographs of the ovumsperm encounter that leads to conception. Conception Stage Isador Sadger11 wrote in 1941 that it makes a difference under what emotional conditions the spermatozoon is expelled and how it is received by the ovum. Sadger believed that it is to the benefit of the individual if sexual congress is accompanied by feelings of sensuality and love and if the ovum receives the sperm cell with "open arms". Sadger quotes one of his patients as saying in therapy, "I had a penis earlier, namely, the umbilical cord. After birth it was gone. For this castration I can never forgive my mother." Since no person in their right mind would ever arrive at such a conclusion on their own, I assume that Sadger would teach his patients some of his theoretical constructs and that subsequently they would distort their own experiences accordingly. In Greek mythology, we are told of a highway robber, called Prokrustes who would offer wayfarers hospitality under the condition that they fit exactly his bed. Since most travelers were either too short or too long, he stretched the short ones and cut the legs off the tall ones, killing them in the process. I am afraid that interpretations based on rigid and unsubstantiated theories are Procrustean in nature, violating the individual's psyche. They tend to produce mindless conformity instead of real understanding. This brings me to another point about psychotherapy. Intellectual insight, unless it is also accompanied or later followed by an emotional insight, by itself does very little to produce a real shift in personality. Unfortunately, it is not easy to achieve profound, total body-mind insights. It is for that reason that Freud late in his life gave up on trying to facilitate his patients' reliving of their childhood traumas with all the attendant emotions and rather settled on trying to convince them of the correctness of his interpretations, hoping that this would be sufficient. It wasn't and it isn't. An intellectual insight, whether it is about the Oedipus complex or conception, no matter how valid, will lack impact unless it is richly charged with feelings, emotions, sensations, images, etc. Without going into details, suffice it to say that any technique which helps clients to contact their feelings or their bodies will facilitate emotional insight, while techniques that engage the mind alone are rarely effective. Several years ago I recall working with a 45-year-old man who complained of feeling angry. I encouraged him to go deeper into his anger, to become his anger. I will describe what happened in the present tense. John identifies his rage as belonging to his father. He feels part of his father's desire for wanting to have sex with his mother. Next he feels his mother's passivity and rejecting attitude towards his father. He feels the clash between his father's aggression and his mother's coldness and vulnerability. On talking about this

experience it becomes very clear to him how all his life he has been struggling to overcome these same impulses in himself. He is one of the most ambivalent people I know. Introspection and psychotherapy are his life. Suggestions to alter his lifestyle are ignored or met with hostility. In my experience, clients who are not willing to alter their lifestyle, to practice new ways of being and relating-in other words, to expend some energy and take some risks in real life-will not change on a deep level. Oviduct Stage Many adults discuss their body image or have dreams in which they experience themselves as a sphere, a ball, a balloon, hollow, with no arms, no legs, no teeth. They will say: "I do not feel myself to have a front, back, up, down, or laterality. I float, fly, spin. Sensations come from everywhere. It is as though all I am is a spherical eye."4 This description corresponds closely to the way the blastula would feel on its journey down the Fallopian tube. Implantation Stage Most embryologists now believe that 50 percent of fertilized ova are aborted between the time of conception and the first few days after implantation. This very high rate of miscarriages is largely due to the fact that one-half of the proteins in the blastula are from the sperm. The sperm is, by the rules of the immune system, tagged as a foreign body. Therefore, the endometrium reacts to the blastula as if it were an alien intruder and mobilizes its defensive forces in an attempt to defeat it. Depending on the outcome of this struggle, the blastula either dies or succeeds in establishing a foothold, usually in the posterior wall of the uterus. These physiological events may be experienced psychologically as a battleground analogous to conception. They may serve as the template for the feelings of pleasure associated with pushing, getting ahead, diving fearlessly into things, exploring new horizons with confidence or trepidation, always moving cautiously ahead (putting feelers outchorionic villi?). Many people spend their lives trying to get into a club, a fraternity, a university or a group of friends. They have dreams of quicksand, swamps, storms, winds, shipwrecks, breaking into pieces. They may complain of an inability to get into what they are doing, or be suffering from inexplicable fatigue, lack of willpower and intellectual impotence.12 R.D. Laing, who treated many severely disturbed patients, relates the following two conversations that seem to reflect the pull of the implantation struggle on the patient's present feelings. Client A: I feel I am clinging to crumbling rocks liable to be swept away in the torrent, hanging on for dear life, trying to get a foothold, never seeming as though I can get into what I'm doing. Always trying to get in. Everything glances off me. I feel in a whirl as though I'm turning round and round faster and faster and I could whirl away forever.13 Client B: I feel like a sponge. A deep underwater creature like an anemone. I'm sodden with terror suffused with fear, a terrified sponge. I'm helpless. I can't move. It's meaningless to get out of it by running away, talking I'm quivering all over.14 Uterine Stage Since the early days of Freud, orthodox psychoanalysts have held fast to the belief that any dreams about or recollections of prenatal events were fantasies due to "retrojection." A number of analysts, beginning with Otto Rank,15 Nandor Fodor,16 Francis Mott,17 Lietaert Peerbolte,18 Gustav Graber19 and Friedrich Kruse20 to name but a few, deviated from this party line and had to suffer unpleasant consequences. The problem with the work of these true pioneers was that though they ascribed much more mental capacity to the unborn than their contemporaries, they never really freed themselves of psychoanalytic dogma. They simply recycled all the old concepts so that, for example, the Oedipus complex became a competition between the sperm and the father for the love of the ovum; or the loss of the umbilical cord at birth became equated with castration. Thus we were still left with Procrustean interpretations that stretched or truncated the truth. Nandor Fodor, though vague about his methodology, was the first analyst to advocate birth simulation techniques. He suggested that nurseries should provide tunnels through which children could crawl safely and abreact their birth traumas. I will relate here one of his patient's dreams and Fodor's interpretations of it in order to elucidate another important factor about working with dream symbolism from a prenatal perspective. The case concerns an adolescent girl who dreamed the following dream: On Waikiki Beach. Beautiful scenery. Pools of water left in the sand. The air is translucent and warm. I am walking with Mummy and Daddy. Suddenly, I see a huge shark cutting ahead of us. We cannot all escape. I have to sacrifice myself for Mummy and Daddy. I wrestle with the shark on the ground. It changes into a very good looking colored boy, then it becomes a shark again. I tell the others: now is the time to knife it. Fodor

comments: The dreamer confessed that the wrestling with the shark gave her very pleasurable sensations. She was ashamed to mention them in her narrative. The "colored" boy represents the shame, while change of the huge shark into a male of the human species plainly reveals the sexual character of the struggle. The sacrifice shows her as the victim of parental sexual pleasures in a pre-natal setting. The hot tropical beach is a symbol of the womb, life emerging from the warm water of the sea. The shark is the father's invading organ.21 I am greatly troubled by this kind of interpretation. There seems to be no attempt on Fodor's part to ask his patient for associations to Waikiki Beach, for example. What if her parents had just returned from a holiday in Hawaii recently, or what if Waikiki represented to her an ideal escape from an intolerable home situation? Wouldn't these things make a difference? The patient dreams that she has to sacrifice herself for "Mummy and Daddy"; what does that say about her relationship to her parents, her self-image? In what other ways does she express self-destructive tendencies? She wrestles with the shark who changes into a colored boy and back again into a shark. She wants her parents' help in killing it. I don't for a moment believe that the shark is, as Fodor states, the father's penis. I do think it is some dark energy, the Jungians would say shadow material, probably of a sexual nature that the adolescent girl is trying to come to terms with. In other words, there is every indication that the dream deals with problems typical of an adolescent. Only after working through all aspects of the dream and exploring every tangible association would I consider delving into her prenatal past.22 I would do so with questions such as, "Have you ever felt this way before?" or by trying to get into the feeling. Our dialogue might go something like this: Therapist: How did you feel when you saw the huge shark? Client: Scared, I felt really scared. Therapist: What else? Client: That I was trapped, I could not escape. Therapist: If you are willing, I would like you to close your eyes and really feel that feeling. Yes, just really sink into it. Client: My whole body is shaking, I seem to be ... You can see how the client could end up in the birth canal or by the same token perhaps in a locked closet at age six. We don't know what a person needs to work on and we must not presume to know if we want to engage in humanistic rather than mechanistic therapy. So even if you are a pre- and perinatal expert, remember Freud's old dictum: "Sometimes a cigar is just a cigar." My advice is to work with the obvious first and then, if the client indicates an interest in probing deeper, to follow the tracks in the sand. There are numerous ways in which one can gain access to the uterine stage of development and womb life in general. I shall categorize some of these approaches and describe them briefly. I. Extra-therapeutic 1/ Spontaneous 2/ Religious and spiritual practices 3/ Psychotic breakdowns II. Physiologically induced: 1/ LSD, Ritalin, hallucinogenics 2/ Holotropic therapy-Stanislav Grof 3/ Rebirthing-Leonard Orr &Sondra Ray III. Abreactive and feeling-oriented therapies: 1/ Body therapies Orgone therapies-Wilhelm Reich Bioenergetics therapy-Alexander Lowen Rolfing-Eva Reich 2/ Natal therapy-Elizabeth Fehr, Leslie Feher 3/ Primal Therapy-Arthur Janov I. Extra-therapeutic. Since the focus of this paper is on the therapeutic approaches to pre- and perinatal material, I shall not discuss the class of phenomena I have called "extra-therapeutic". II. Physiologically induced. There are many reports in the literature on the regressive effects of a wide variety of substances from peyote to LSD. The most thorough research on the effects of LSD was conducted by Stanislav Grof and published in 1976 in a truly ground-breaking book, The Realms of the Human Unconscious.23 Grof's model of the unconscious consists of three levels: the Freudian psychodynamic, the Rankian perinatal and the Jungian transpersonal. Many substances from LSD to Ritalin and activities such as dancing, drumming and fasting alone or in combination can produce hallucinations and sometimes flashbacks to intrauterine life. When LSD became an illegal drug in the U.S.A., Grof was forced to abandon his clinical work with LSD and gradually developed a method of accessing early memories-a method he called Holotropic Therapy. In holotropic therapy, the client is taught to breathe in a rhythmic way while listening to powerful classical music. As the person continues to breathe deeply and evenly, the carbon monoxide level in his blood drops, which brings about painful spasms of the jaw and hands and somehow facilitates the creation of mental images. These images run the gamut from typical LSD-type color and shape hallucinations to past-life flashbacks to the reliving of pre- and perinatal memories. During the breathing part of the process, the therapist encourages the client to go deeper into his sensations and

feelings and will often exert pressure on various parts of the client's body. When the music stops the client is asked to draw a mandala and then relate his experiences. Rebirthing, a term popularized by Leonard Orr &Sondra Ray,24 is very similar to holotropic therapy in its emphasis on deep breathing. During rebirthing, clients often discover that as a result of a traumatic event at their birth or prior to it they formed negative life scripts such as: Life is a struggle I am not wanted I can't get what I need. Rebirthers teach their clients to counteract these negative scripts with positive affirmations, such as: Life is easy and wonderful I am wanted and loved I can always get what I need. I believe that all of these approaches may be beneficial. A lot depends on the knowledge and skill of the therapist. None of these techniques, unfortunately, work with everyone. No one therapy guarantees results. Any therapist who tells you otherwise is either deluded, demented or determined to dupe you. When in spite of their best efforts clients fail to reach their goals it is important for therapists to refer them elsewhere. An inability to relive an intrauterine event or birth or conception should not be seen as a failure on the part of the client or of the therapist but rather as a function of our present state of knowledge that cannot in any scientific way predict which method, technique or therapeutic school will work with any particular person. Clients whose major motivation for entering psychotherapy is the desire to recall a specific time or event in their lives should be clearly informed by their therapists that the approach used by the therapist, though helpful in a majority of cases, does not work in every instance. This kind of statement may save both parties a lot of grief in the future. III. Abreactive and feeling-oriented therapies. Wilhelm Reich25 developed his orgone therapy in the 1930s in an attempt to circumvent the rational mind and its resistance by working on the body. It was later modified and extended by Alexander Lowen26 in his writings on Bioenergetic Therapy. At about the same time Eva Reich,27 who attended the first PPPANA Congress in Toronto in 1983, started to elicit repressed memories by deep tissue massage of adults and children. Natal Therapy originated with Elizabeth Fehr in the 1970s and her daughter Leslie Feher popularized it with her book The Psychology of Birth.28 Natal therapy attempts to wed individual, verbal psychoanalytic sessions with an intensely emotional, nonverbal group rebirth. Feher describes the group experience as follows: The patient comes in with his own pillow, blanket and slippers, and a package of his favorite food to share with others. Usually, the larger the group where the non-verbal experience occurs, the more effective the therapy, and so visitors, friends and colleagues are invited to come as observers. Each patient as well brings along a companion to work with him during the therapy. We sit in a circle, and each person introduces himself and explains his interest in natal therapy. Those who wish can summarize some of the effects they have felt in themselves as a result of previous sessions. The lights are dim and there is a heartbeat going in the background. Everyone is then required to lie down with a pillow and participate in a fantasy trip that helps relax the body and the mind and carries the participants backwards through adulthood, childhood and then into infancy. In his first rebirth experience, the patient is primarily in control. He lies down on a mattress. His arms are folded and, while maintaining eye contact with the therapist, he takes three deep breaths. His hands are passed to another group member, as he closes his eyes. In this state he is quite aware of himself and his environment. Then he begins to push with his hands and feet. He begins to move as he does so, slowly, subtly, beginning to sink deeper within himself, until he reaches another state of consciousness: one similar to the point just prior to falling asleep. The world is both real and unreal. Voices are heard from others in the group, but only half attended to. And then he is born in triumph, or sadness or desperation. After rebirth the patient is hugged into the world by his companion, his brow wiped clean of sweat, his slippers are placed on his feet, he is wrapped in a blanket and then, when able, helped to the bathroom. Upon his return, he is given milk and baby food, and his reactions are discussed. We are currently experimenting with something new, where the individual is required to wear an artificial umbilical cord for a week prior to the therapy and it is cut off at the birthing. Some patients have a clear awareness, while others retain only vague recollections. Some recall days later, although for others, whose trauma is too painful, the memory may never surface, even after many repetitions of natal therapy. But the value of the therapy is not contingent upon memory; only upon the coded messages the patient communicates. It is the movements that

symbolize and piece together the problem.28 The best known body-oriented, regressive, abreactive therapy is Arthur Janov's Primal Therapy. Unlike Feher, Janov29 discourages intellectualizations and interpretations and stresses the total reliving, which he calls "primaling," of early traumatic events. Similarly to Feher, he builds expectations in his patients and uses a wide variety of techniques from isolation to body work to intensify their feelings. Janov has written a lot about the importance of working with people from the inside out instead of from the outside in. Techniques such as hitting a pillow to put a client in touch with her anger or crawling through a tunnel of mattresses to simulate birth would be examples of techniques imposed from the outside. What Janov advocates is enhancing feelings that emerge organically from the client rather than imposing a therapist's interpretations or techniques on the patient. In my experience, primal patients more than any other patients are extremely well informed about the therapy. They have all read one or more of Janov's books and by doing so have been primed to expect major emotional reactions while undergoing this form of therapy. Contrast this with your average psychotherapy patient who at best has read a bit of Freud or Jung but has no idea what to expect in psychotherapy. Thus, we have several factors operating in these therapies which make the results suspect. These are: subtle prior indoctrination, group pressure to conform, and the need to become part of an inner circle of idealized authority. Personally, I prefer to work with people who enter therapy without any preconceived notions about it. I do very much support Janov's inside-out principle, the need to re-experience past events as fully as possible, and avoidance of intellectualizations. There is no doubt in my mind that any technique that is body-oriented and appropriate to what the client is experiencing in the moment will facilitate therapeutic progress. Unfortunately, not all patients are open to be worked with in that way and not all therapists are comfortable working in this manner. Labour and Birth Stage As we are discussing various ways of eliciting early pre- and perinatal material, and/or working with material that emerges spontaneously but apparently originated in the pre- and perinatal period, it is neither impossible nor desirable to divide schools of psychotherapy into those which only focus on birth and those that only focus on intrauterine life. However, for the sake of clarity and organization, I have arbitrarily placed into the previous section the "physiologically induced and the abreactive therapies" while in this section I want to deal with insight-oriented therapies for children and adults. IV. Insight-oriented therapies: A. Infants and children 1/ Psychoanalysis-Anna Freud, Melanie Klein, A. Piontelli 2/ Audio-psycho-phonology-Alfred Tomatis and Anne Marie Saurel 3/ William Emerson 4/ Holding Therapy-Martha Welch and Rima Laibow B. Adults 1/ Holotropic Therapy-Stanislav Grof 2/ Hypnotherapy-David Cheek and David Chamberlain 3/ Evocative Therapy-Thomas Verny IV. Insight-oriented therapies A. Infants and children: Freud believed in the significance of the birth trauma in shaping personality, but he did not think that it was accessible by psychoanalysis. Anna Freud30 modified the technique of psychoanalytic investigation to the treatment of children. At the same time, Melanie Klein31 developed a method based on interpretation of the meaning of child's play without recourse to verbal communication. I think Klein has done irreparable harm by her formulations of the infant psyche as a reservoir of paranoid and aggressive impulses. According to Klein, every child becomes depressed when weaned because it interprets weaning and the consequent loss of the mother's breast as the result of his or her destructive fantasies. Klein pushes the oedipal conflict back to the first and second post-natal years, and dates from the same period the origin of a cruel, persecuting super-ego which she considers the source of later paranoid delusions. I think Melanie Klien is a good example of how psychoanalysts and others anthropomorphize children, infants and unborn babies. To the outside observer there is nothing to indicate that her concepts are related to the individual children's mental processes. On the other hand, there are many psychoanalysts who are working with children today in very positive ways. One such psychiatrist who not only sees children but has studied them with the aid of ultrasound in utero is Alessandra Piontelli.32 In her paper "Pre-natal Life and Birth as Reflected in the Analysis of a 2-Year-Old Psychotic Girl",33 Piontelli clearly connects her patient's problems with her pre- and perinatal experiences. Regrettably, for every Piontelli there are probably 10 or 100 child psychotherapists who are ignorant of the effects of pre- and perinatal traumas on the human mind and who would diagnose Piontelli's patient as suffering from childhood autism, then nuke her

with tranquilizers and confine her to an institution. At present, several innovative approaches to the treatment of severe childhood problems have been developed, based on the assumption that pre- and perinatal life affects and in some cases damages personality. Since the focus of this paper is the psychotherapy of adults I shall discuss these new therapies for children and infants only briefly. The oldest approach amongst these is the one practised by Anne Marie Saurel, a student of Alfred Tomatis in France who presented at the First International Congress on Pre- and Peri-Natal Psychology in Toronto in 1983. Saurel's therapy34 uses a device called the electronic ear, which when placed over the child's ears permits him to listen to his own mother's voice distorted electronically to what the baby would have heard in the womb. Each day children spend some time in the "cabine de maternage", a small oval-shaped room containing a bathtub, lighting that can vary from blue to orange, loudspeakers for playing the treatment tapes and a place for massage and relaxation. In this way the patient is brought progressively forward to a "rebirth". As in all the new child therapies, the active participation of both parents is sought. Saurel's program is residential and usually lasts several months or even years. Another pioneer in the field of child psychotherapy is William Emerson, who has spoken often at PPPANA meetings. He uses techniques which either simulate pre- and perinatal traumas in various ways or else draw out the material.35 An example of the former is body massage; of the latter, facilitating parental dialogues that take the child back to her time in the womb. In conjunction with these techniques, cranial and chiropractic treatments are also utilized. Martha Welch,36 a psychiatrist in New York City, first introduced Holding Therapy in the U.S.A. Rima Laibow, the chair of the IV International Congress of PPPANA at Amherst in 1989, has spoken and written extensively on the same subject. Laibow describes Holding Therapy as: ... a powerful method in which a pair of bonded partners work together with a therapist using specific techniques in order to repair basic deficits in maternal-infant bonding and attachment afflicting the ability of the partners to develop, love and communicate effectively. Both partners undergo healing so that this deficit is repaired in both mother and child. In all cases in which there has been a spontaneous, volcanic upwelling of memory material, this process has led to a substantial improvement in the pathological symptomatology, behavior and functional level of the child. I did not expect these memories to emerge. I do not solicit or inquire for them and, in most cases, the historical and circumstantial information about the episodes was not available to me until memory surfaced and I solicited additional information. Since they are being held "in storage," the memories then become available for retrieval as overwhelming powerful associations to the regressive experiences which are fostered in the process of Holding Therapy itself.37 According to Welch and Laibow, forcible holding of autistic children by their mothers is the most effective way to establish a nurturing bond between child and mother. While Holding Therapy case reports are very persuasive, it is a method that demands from its practitioners huge investments of time, effort and personal courage. I believe that the Holding Therapy is a promising new approach to the treatment of severely disturbed children. B. Adults: Stanislav Grof has applied his psychoanalytic training in the service of LSD-assisted therapy and holotropic therapy, as already described. I believe his major theoretical contribution is his discovery of what he calls four "perinatal matrices" of consciousness. His first matrix, "symbiotic unity," refers to feelings and memories from the time before the onset of labour. The "antagonism" matrix occurs at the onset of labour, followed by "synergism" as the baby moves forward in the birth canal, and finally "separation" when the baby is born. I would recommend that all therapists working in an insight-oriented way familiarize themselves with the relationship between certain symptom clusters and perinatal matrices. I think this knowledge will improve considerably their ability to help clients with problems that originated at birth or prior to it. Next I would like to discuss hypnosis as a method of investigation, memory retrieval and therapy. The two major figures in this area are David Cheek and David Chamberlain. Cheek38,39 has described his ideo-motor approach to hypnosis in many papers and books. Essentially, it consists of a brief hypnotic induction using a pendulum, followed by a suggestion that in response to a question to which the answer is in the affirmative one of the patient's fingers move. When a finger moves it is designated as the "yes" finger. This is followed by identifying the "no" finger and the "Fm not ready yet" finger. Sometimes during questioning the patient's hands

will drift off into unusual positions and other kinds of spontaneous movements. The therapist can facilitate whatever is involved, somewhat as follows: Sometimes the unconscious can tell a story with movement... sometimes it becomes clear what that is about... There may or may not be images, memories, thoughts, voices, or feelings associated with those movements ... As that continues, you may begin to experience certain feelings more (or less) strongly ... simply allowing that to continue all by itself until you know ... Allowing the creative healing forces (inner mind, higher self, etc.) to continue in just that way, until the inner work is completed for now ... And as those hands finally come to rest (when it is obvious that they are), your unconscious can make available just one or two thoughts that we need to understand so that we can further facilitate the healing next time.40 Chamberlain has used more conventional inductions and questioning to obtain a variety of birth and pre-birth reports. Chamberlain writes that: A recent critical review of experiments in this field confirmed that hypnotized subjects do have significantly greater recall for both verbal and nonverbal material, provided it is meaningful and is obtained by a method called free recall. Studies show that memory is facilitated, too, when the remembered event contains strong images, emotions, sensations, or meaning. Memories can be spoiled, however, if the interviewer asks leading questions, suggests answers, or uses interviewing techniques that hurry and confuse the person remembering. Narrative moment by moment birth reports are rare, although many people are quite capable of having them. These rather amazing stories have all the advantages of mature language, because babies have grown up. They reveal lucid thoughts and deep feelings going on at the time of birth.41 To practice the kind of creative hypnosis that people like Cheek and Chamberlain employ, one needs to possess not only a special aptitude for it, but also a total confidence in its efficacy. Since I have never been hypnotized, though I have tried to be several times, I lack the faith necessary to succeed in this method. I also may lack the talent. For these reasons I have developed a therapy system that does not use hypnosis. I have called my approach Evocative Therapy because of its ability to evoke memories, sensations and feelings in a gentle, humanistic fashion. I shall describe some of the major elements of evocative therapy below. The people I see in my practice may be divided into two groups. In group A are the patients who consult me for a variety of symptoms such as anxiety, depression, psychosomatic disease, sexual dysfunction and the like. In the course of their psychotherapy some material may emerge, most frequently in dreams, that I feel may have pre- or perinatal origins. Group B consists of clients who enter therapy because they either wish to recall some earlier traumatic event such as in utero death of a twin or who have specific problems related to pregnancy or the wish for pregnancy. While I work the same way with all my patients, I am more goal-directed and past-focused with people in the second category. Because I believe that in order to undergo any real change patients must live therapy 24 hours a day, seven days a week, or at least a lot more than fifty minutes once a week, I tape all our sessions on an audio tape. They are then requested to listen to this tape at least once prior to their next session. Patients are also asked to keep a journal. In the journal they are to write down thoughts or feelings that they had following their session. In addition, any dreams, any emotionally charged events, either of a positive or negative nature, that occur during the day and any flashbacks to childhood or beyond are to be entered in the diary. In this way, clients are taught right from the start to take an active part in their therapy instead of looking to the therapist as the person with all the power and magic. When I work with dreams I usually do so on four levels. The first is the here-and-now, reality level. Thus, if the client is a woman called Anne who dreamt that she had an argument with her boss Peter, we would first look at her relationship with the boss. When we have run dry, I might proceed to the second, Freudian level. For example, if the boss is an older man who reminds her of her father, we could investigate some of Anne's ambivalent feelings towards her father and perhaps her relationships with men in general. From here we could go on to the third, Jungian level, and identify the boss as representing her animus or masculine aspect. Often a good way of reaching this third level is to employ the Gestalt technique introduced by Frederick Peris.42 If the client wanted to do that, I would place an empty chair in front of Anne and ask her to sit in it and become her boss Peter. When she felt sufficiently immersed in being Peter, I would ask her to speak as Peter to Anne. When Peter has gone as far as he can, I would ask the

patient to move back into her chair, become herself again and respond to what Peter has just said. We would switch roles back and forth until we reached a resolution or an impasse. By watching for and refocusing the patient on changes in breathing patterns, the appearance of inappropriate facial expressions or bodily movements, such as a sudden shifting of the foot, a clenching of the fist, or expression of emotions like crying, one can reach an even deeper pre- or perinatal layer. Usually, with a question such as, "what are you experiencing right now?" or "what does your right fist want to do?", the therapist can facilitate the reliving of some very early traumas. When a patient wants to uncover forgotten memories I routinely employ the technique of guided imagery.431 have found that I get better results with guided imagery if the patient is in a receptive and relaxed state. To achieve this I practice the well-known progressive muscular relaxation formula. While I instruct the client to tense a muscle group such as the calves or the thighs, I also insert suggestions of a hypnotic nature such as: "With each breath that you take, you are choosing to go deeper and deeper into a perfect state of relaxation;" or "As you become relaxed, you will pay less attention to your analytic left brain and you will connect more with your feeling right brain. Let any old feelings or memories that you want to re-experience gradually rise to the surface of your awareness." For all intents and purposes this type of approach is a hypnotic induction but it avoids noncompliance. Very few patients are so resistant that they cannot follow these simple instructions. When a sufficient state of relaxation has been achieved, I can take the person back to their conception or any point along their intra or extra-uterine life by simply saying: "Go back now to the time in the womb when you first heard your mother argue with your father," etc. Or, I can start with an accurate description of the physiological events of conception, journey down the oviduct and implantation. It would sound something like this: "One single round egg is floating in the oviduct surrounded by a dozen or so sperm cells. They are all swimming as fast as they can towards the egg. As you look at this scene, which of these cells do you connect with? Is it one particular spermatozoa or is it the ovum? Notice your reactions. Do you have any sensations, feelings or thoughts right now? Very soon one of the spermatozoa reaches the ovum and enters it. Try to see this as clearly as possible. What does it feel like?" In this way I could move on to implantation and the first trimester. At this point the patient could be asked to return to the present, sit up and talk about his experiences. In the next session we could repeat the procedure but start where we left off in the regression, that is, at three months in the above example. One can access repressed memories more indirectly by first engaging in progressive relaxation and then by saying: "Now I will play some classical music for you. When the music starts please allow the music to take you wherever you need to go. Do not think, do not try to analyze or appreciate the music. Just feel it the way you would feel the rays of the sun on a warm summer day, open yourself up to the experience and go with it." All suggestions are made in a low, melodious voice with lots of pauses and references to what the patient is doing. If, for example, the patient shifts his body I'll say: "That's right, get more comfortable so that you can really relax and go further back in time." If clients have few or no definite images or feelings during the music regression I will hand them a large sheet of sketching paper and a box of crayons and ask them to draw their experience, whatever it was. It's really quite astonishing how much pre- and perinatal symbolism emerges in the process. Other ways of evoking memories of womb life are: showing clients slides or movies of prenatal development or asking clients to look at illustrations in books such as Lennart Nilsson's A Child is Born. Attending a birth can also be a pretty powerful trigger of one's own birth memories. And of course, becoming pregnant often leads to the emergence of pre-birth memories. I have found these techniques to benefit infertile couples, women with frequent miscarriages, women wanting to contact their babies before terminating the pregnancy, women planning to relinquish their babies for adoption and men and women with a variety of symptoms which they themselves diagnosed as having been caused by pre- or perinatal traumas. PSYCHOTHERAPEUTIC INTERVENTIONS In the course of this paper we examined psychotherapeutic interventions which were used to facilitate the recall of pre- and perinatal memories, or that were employed with material that emerged in psychotherapy and seemed to relate to clients' pre- or perinatal life. My own subjective criteria for interventions that are humanistic, rational and ethical are: 1. Interpretations must be linked to the

client's mental processes and not the therapist's. 2. Avoid Procrustean interpretations based on rigid and unsubstantiated theories. They tend to produce mindless conformity instead of real understanding. 3. Therapists who follow their patients' communications provide a safe and accepting environment for them. Only in such a relationship can patients finish the unfinished business of the past. 4. Intellectual insight unless accompanied or followed by emotional insight is of little benefit. 5. If one aims for a deeper reconstruction of the psyche it is essential that the client make some changes in his real life. 6. When working with dreams it is best to apply the old onionpeeling metaphor. Start with the outer layer of here-and-now reality and gradually progress towards the core. As you do you will pass through the Freudian, the Jungian, the pre- and perinatal, and finally, the transpersonal layer. 7. No one technique works with every person. Therefore, a therapist must be prepared to experiment with a smorgasbord of approaches such as body work, art, hypnosis, guided imagery, rhythmic breathing and other simulative and evocative methods. 8. No consideration of pre- or perinatal traumas has value unless subsequent traumas are also worked through and vice versa. SUMMARY This paper is an attempt at a historical survey of psychotherapies that have successfully accessed pre- and perinatal memories. A variety of ways are discussed, in which psychotherapists work with material that is felt by the therapist or the client to be linked to pre- or perinatal life and certain desirable criteria for the practice of humanistic and rational pre- and perinatal psychotherapy are suggested. It is proposed that the systematic study of material that emerges in the course of psychotherapy is facilitated by identifying it with a specific stage of pre- or perinatal development. References REFERENCE NOTES 1. Laing, R.D. (1983). The voice of experience. Bungay, Suffolk, Eng: Pelican Books, pp 50-52. 2. Winnicott, D.W. (1958). Collected papers: Through paediatrics to psychoanalysis. New York, Basic Books, pp. 177-178. 3. Spielrein, Sabina, (1912). Destruction as a cause of coming into being, Jahrbuch für psychoanalytische und psychopathologische Forschungen 4:465-503, Vienna. 4. Laing, R.D., (1976). The facts of life, New York, Pantheon Books. 5. op cit., p. 34 6. op cit., p. 36 7. DeMause, Lloyd (1982). "The Fetal origins of history." Foundations of psychohistory, New York, Creative Roots, Inc. 8. Irving, Michael (1989). Natalism as pre &perinatal metaphor, PPPJ 4(2) Winter 1989, pp 83-110. 9. Verny, Thomas (1991). Natalism in Myths, Fairy Tales and Rites of Passage. V International Congress of PPPANA, Atlanta. Available on audio-cassettes from Sounds True, Boulder, CO. 10. Janus, Ludwig (1991). Wie die Seele entsteht. Hamburg, Hoffmann und Campe. 11. Sadger, Isadore (1941), "Preliminary study of the psychic life of the fetus and the primary germ cell." The Psychoanalytic Review 28(3) July 1941. 12. Laing, R.D. (1976) op.cit., p. 45 13. Laing, R.D., op. cit., p. 46-47 14. Laing, R.D., op. cit., p. 48 15. Rank, Otto (1952), The trauma of birth, New York, Robert Brunner. 16. Fodor, Nandor (1949), The search for the beloved, New York, University Books. 17. Mott, F.J. (1964), The universal design of creation, Edenbridge, England, Mark Beech. _____ (1960). Mythology of the prenatal life, London, Integration Publishing. _____ (1959). The nature of the self, London, Alien Wingate. 18. Peerbolte, M.L. (1975). Psychic energy, Amsterdam, Servire Publishers. 19. Graber, Gustav &Friedrich Kruse (1973) Vorgeburtliches seelenleben, Munich, Goldman MEDIZIN. 20. Kruse, Friedrich, (1969). Die Anfange Des Menschlichen seelenlebens, Stuttgart, Ferdinand Enke Verlag. 21. Fodor, Nandor, op. cit. 22. Fodor, Nandor, op. cit., p. 341 23. Grof, Stanislav (1976), The realms of the human unconscious, New York: E.P. Dutton &Co. 24. Orr, Leonard &Sondra Ray, (1977). Rebirthing in the new age. Millbrae, CA, Celestial Arts. 25. Reich, Wilhelm (1949). Character analysis. 3rd Ed., New York, Orgone Inst. Press. 26. Lowen, Alexander (1967). The betrayal of the body, New York, Macmillan Publ Co. 27. Reich, Eva (1983), Gentle bioenergetics applied to the childbearing year. Syllabus of Abstracts, 1st International Congress on Pre &Peri-natal Psychology, Toronto, Canada. 28. Feher, Leslie (1980), The psychology of birth, New York, The Continuum Publishing Corp. 29. Janov, Arthur (1970). The primal scream. New York, Putnam. _____(1983). Imprints, New York, Coward-Mc Cann Inc. 30. Freud, Anna (1946), The Psycho-analytical Treatment of Children: Technical Lectures and Essays, London, Imago. 31. Klein, Melanie (1937), The Psychoanalysis of children, London, Hogarth. _____(1950), Contribution to psychoanalysis, London, Hogarth. 32. Piontelli, Alessandra (1992), From fetus to child: An observation and psychoanalytic study, London,

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