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The Importance of Integrating Pre- and Perinatal Issues into Bioenergetic Analysis

Wera Fauser

Abstracts

English

This article deals with the importance of integrating pre- and perinatal issues into Bioenergetic Analysis (BA), since our individual story begins long before we can look into our mother's eyes. The pre- and perinatal period creates our first foundation, our first grounding and our first attachment in this world and the way we experienced our time in the womb and our leaving this first abode and what happened in these earliest moments and days can strongly affect our entire later life. After an introduction, a short historical survey and a chart depicting for body-oriented therapy relevant stages of prenatal development, I will describe examples of pre-and perinatal trauma. For some of these examples clinical vignettes are presented that should emphasize that the consideration of these earliest themes are not to be neglected especially in body-oriented therapeutic methods like Bioenergetic Analysis.

Key words: prenatal development, pre-and perinatal trauma, early attachment, therapeutic procedure

German

Dieser Artikel handelt von der Bedeutung, prä- und perinatale Themen in die Bioenergetische Analyse (BA) zu integrieren, da unsere individuelle Geschichte schon lange vor dem ersten Blick in die Augen unserer Mutter beginnt. Die prä- und peri-

natale Periode stellt unser frühestes Fundament, unser erstes Grounding und unsere erste Bindungserfahrung in der Welt dar und die Art und Weise, wie wir die Zeit in utero erlebten, wie wir unsere erste Behausung verließen und was in den ersten Momenten und Tagen post partum mit uns geschah, kann unser ganzes späteres Leben stark beeinflussen. Nach einer Einführung, einem kurzen historischen Überblick und einer Tabelle der für die Körpertherapie relevanten pränatalen Entwicklungsstadien werde ich Beispiele für prä- und perinatale Traumen aufzeigen und zu einigen davon Fallbeispiele präsentieren, die unterstreichen sollen, dass eine Betrachtung dieser frühesten Themen besonders in körperorientierten Methoden wie der BA nicht vernachlässigt werden sollte.

French

Cet article traite de l'importance d'intégrer en analyse bioénergétique (AB) les problématiques prénatales et périnatales puisque notre histoire individuelle commence bien avant que nous puissions regarder dans les yeux de notre mère. Les périodes prénatales et périnatales créent nos toutes premières fondations, notre premier enracinement et notre premier attachement au sein de ce monde. Ce que nous vivons dans l'utérus et ce que nous éprouvons en quittant cette première demeure, ce qu'il se passe durant ces tous premiers moments et ces tous premiers jours, peut nous affecter profondément, et ce, pour le reste de notre vie. A la suite de l'introduction, d'une brève étude historique puis d'un tableau décrivant les étapes pertinentes du développement prénatal à l'intention des thérapeutes psychocorporels, je donnerai quelques exemples de traumas pré et périnataux. Des vignettes cliniques illustratives montreront combien nous devons prendre en compte et ne pas négliger ces thèmes, notamment en thérapie psychocorporelle telle que l'analyse bioénergétique.

Spanish

Este artículo aborda la importancia de integrar los problemas pre-perinatales y perinatales en el análisis bioenergético (BA), dado que nuestra historia individual comienza mucho antes de que podamos mirar a los ojos de nuestra madre. El período pre-perinatal y perinatal establece nuestra primera fundación, nuestra primera experiencia de arraigamiento, nuestra primera experiencia de apego en el mundo y la manera en la que experimentamos el tiempo que pasamos en el útero, así como la

partida de esta primera morada y lo que tuvo lugar durante esos momentos y los días anteriores. Todos estos factores pueden afectar inmensamente el resto de nuestra vida. Después de una introducción, una breve encuesta histórica y un gráfico que representa la terapia de orientación corporal de las etapas relevantes del desarrollo prenatal, describiré ejemplos acerca del trauma pre-perinatal y perinatal. También introduciré viñetas clínicas con ejemplos relevantes que enfatizan la importancia de tomar en consideración y no descuidar los temas pre-perinatales y perinatales, especialmente cuando se trata de métodos terapéuticos orientados al cuerpo tal como el análisis bioenergético.

Italian

Questo articolo riguarda l'importanza di integrare le problematiche pre e perinatali nell'Analisi Bioenergetica (BA), dal momento che la nostra storia individuale inizia molto prima di quando possiamo guardare nostra madre negli occhi. Il periodo pre e perinatale crea le nostre prime fondamenta, il nostro primo grounding e il nostro primo attaccamento in questo mondo e, il modo in cui abbiamo vissuto nel grembo materno, il nostro lasciare questa prima dimora e quello che è accaduto nei primi momenti e giorni, possono influenzare fortemente tutta la nostra vita successiva. Dopo una introduzione che comprende una breve indagine storica e un grafico che raffigura le fasi rilevanti dello sviluppo prenatale per la terapia ad orientamento corporeo, porto degli esempi di traumi pre e perinatali. A partire da queste vignette cliniche risulta evidente che i temi precoci non non devono essere trascurati soprattutto dai metodi terapeutici ad orientamento corporeo come l'Analisi Bioenergetica.

Introduction

"I am inside a cave with a torch in my hand. I feel very good and think what a funny experience this is. Then I am walking along a dark channel when suddenly my torch starts to flicker and I feel panic that it may lose all its energy and leave me in the darkness. Will it last until I can manage to get out of here? I doubt it. I am sure that nobody will ever find me in there. I wake up shivering and in total fear of dying." (Birth-dream of a client, a wanted child with a Blue-Baby-Syndrome, born with the umbilical cord three times around his neck. A priest had already given him an emergency baptism, because his survival was so unlikely.)

Whereas until the late eighties the embryo and foetus were seen as a mere accumulation of cells without any sensitivity, and newborns and babies up to four to six months were operated on without being narcotized, more and more the realization that the unborn and just born baby is equipped with an independent, elementary emotional life and receptivity and a rudimentary memory has become more accepted in the medical and therapeutic world.

The fact that the unborn and newborn has been able to experience the life in the womb and his birth particularly via body-sensations and physical awareness (Dowling 1991, Emerson 2000, Janus 2000, 2013) is gradually playing a more important role especially in bodily-oriented psychotherapy. It is from our first prenatal and perinatal experiences and impressions that we all derive our fundamental attitudes, our deepest conclusions and convictions about life on earth and about what we might expect from those who take care of us.

Never again in life will we be that vulnerable and dependent on just one person than during that early time. Without our mother we cannot survive the first three quarters of our prenatal months, whereas after birth others can take over the role of the mother and can at least help us to stay alive. Our first abode was absolutely the only place in the world where we could ground ourselves, where we could grow in a hopefully secure and welcoming atmosphere, and the way we could settle there as well as the way we left this abode, has shaped our existence and is engraved in our brain and our body.

If this intra-uterine bonding and grounding or the extra-uterine attachment during the first few weeks and months have been severely disturbed, and in case our birth had taken place under traumatic circumstances, it will have the deepest effects on the entire psychic and physical development of the child (Bauer 2011, Nathanielsz 1999, Schore 1994, Verny 1995). Will the baby be strong, resilient and self-confident or rather weak and not provided with much ability to tolerate stress? Will it be able to keep its temper or will it be nervous, hyper-active or in constant alarm? How will it be capable of concentrating and sleeping peacefully? How much basic trust will it have? How much deeply rooted mistrust? What kind of a character will it form? What kind of diseases might it get later?

This earliest period of our life can also be responsible for the development of mental disorders or psychosomatic diseases (Janus 2013, Nathanielsz 1999, Schore 1994).

The most decisive and most damageable time certainly is the period of the so-called *"foetal programming"* during the first 12 intra-uterine weeks when the organs are being developed and the earliest withdrawal-reflexes come into being (Blomberg 2012, Dowling 1991, Emerson 2000, Nathanielsz 1999).

As undisturbed, relaxed and at ease the unborn had been allowed to live, and the

more powerfully it can enter the earth with no birth complications and of course provided that it has afterwards been cared for and raised in a relatively optimal way, determines how relaxed he can be in his future life.

Fundamental answers cannot be found solely by considering the genes and the experiences days and weeks after birth but by literally going back "to the dark wonderland of womb life" (Verny 2013) and to the roots of pre- and perinatal experiences to find the basic melody of our life. Therefore, this article will focus on these issues and leave aside the obviously also very important and character-forming months and first years after birth. Due to limitations of space only some of the mentioned issues can be described in detail.

1. Historical Introduction

The psychoanalyst *Otto Rank* was the first to acknowledge already in 1924 that the relationship between mother and child begins long before the child is born and that pre-and perinatal memories were true memories. One of his main statements referring to this matter says that prenatal feelings and experiences and the ones during birth could essentially influence the dynamic between therapist and client (Verny 2013, in Janus 2013).

Both Otto Rank and *Gustav Gruber* investigated this subject and described it systematically.

Otto Rank attached more importance to the intra-uterine issues and the birth experiences than to the oedipal complex which in 1926 led to a breach between him and *Freud*, who was not willing to revise or expand his psychoanalytical concept.

Otto Rank could imagine the time in the womb as the very beginning of the mother and child relationship and is considered as the precursor of Ego-Psychology.

In the thirties the Hungarian psychoanalyst *Sándor Ferenczi* realized the importance of the preverbal time in the womb and in the first year after birth and was occupied with the issue of the rejected unborn and baby (*The Unwelcome Child and His Death Drive*, 1929). Not knowing anything about birth-trauma he valued this procedure as an event of omnipotence.

All of the analysts mentioned above, as well as *Nándor Fodor* in the fifties, who also had been interested in this subject and emphasized the traumatic aspects, did not meet with a positive response and remained outsiders.

Alfred Adler rather looked at the aspects of feelings of inferiority and power-

lessness during this period. He was the first psychoanalyst who did not idealize the intra-uterine phase.

In *C. G. Jung*'s archetypes one can also find references to prenatal themes.

Like Freud, *Wilhelm Reich*, had been more concerned with postnatal drive concepts and *Alexander Lowen* followed Reich in this tradition.

During the last three decades research on and the preoccupation with these issues of early life, initiated by classical psychoanalysts, has been taken over by more body-oriented therapists and physicians. Referring to pioneers like *Arthur Janov* (*Early Imprinting*, 1984) and *Stanislav Grof* (*Topography of the Unknown*, 1983), it was *Terence Dowling* and *Alfred Tomatis*, who developed new approaches to help their clients or patients to dive into the pre- and perinatal period of their life. In the eighties Tomatis was the first to re-enact traumatic womb and traumatic birth experiences and he used the mother's voice on tape or in reality as a remedy. Also one of the most important scientists and therapists, *William Emerson*, has been working with children and adults on this theme for more than 30 years now (Schindler 2011, p. 8).

Meanwhile pre- and perinatal issues and early trauma are gradually being considered within the bioenergetic world. For the exciting journey back to the very roots, Bioenergetic Analysis with its definite body-orientation within the frame of a secure and hopefully step-by-step, trustful and warm therapeutic relationship and with its elaborate know-how concerning trauma in general, actually seems to be especially suitable for this task.

Fortunately neurobiological research nowadays affirms the necessity of a physical approach to preverbal subjects. Neuronal network-patterns are prenatally determined by the genetic disposition, but as the neurobiological findings prove, they depend in their evolvement on the experiences within this habitat (Bauer, 2011). *"Prenatal traumata are burned into the brainstem, like Bruce Perry (2005, p. 18) formulated and this prenatal trauma sets the limits for future brain development"* (Schindler 2011, p. 55). These early patterns form strong connections particularly if negative or traumatic experiences have been made which lead to fixed convictions because the foetus or newborn draws all conclusions from his narrow little primary world (Gerald Hüther: *Die Macht der inneren Bilder*, 2008).

Unfortunately, it is normally completely unconscious that this overshadowed world outlook stems from the very beginning of our life and is therefore, of course, too simplified. Moreover one can hardly change it by pure verbal therapy and mere mental insight. Modern brain research has proved that we tend to perceive and repeat what is already known to us and the new and unknown is rather turned off in the brain. Once our first coping strategies are learned we will stick to them and prevent ourselves from learning and trying new solutions.

2. Important Stages of Prenatal Development

Time	Division	Size (ca.)	Characterization
1st day	Early Development	0,1 mm	Conception, Fertilization
day 4–5			Free Blastocyst
day 5–6			Adhesion of the blastocyst on the uterus's mucous membrane. Nidation. At present **the basic plan of body and brain is female**.
3rd week		0,2–2 mm	**Three-leaved embryonic disc**, beginning of the **spine**-development, (primal vortex), **a small brain is functioning after only 20 days. The stem-brain develops first and grows quickly**. Shortly afterwards the heart begins to beat. Nervous cells are spreading all over the body. Skin and brain spring up from the same cell layer (ectoderm). A part of the nervous cells is being locked up in the emerging brain, another part floats in the abdomen and forms the **intestinal brain**. The **unmyelinated dorsal vagus (DVC)** is developing. This enteric system functions almost independently from the central nervous system (Porges, 2011).
4th week	Embryonic Period	2–5 mm	A yolk bag produces stem-cells of leucocytes and erythrocytes, **arm- and leg-buds** can be recognized, **the umbilical cord** is created. The embryo is swimming in the amnionic cavity.
5th–8th week		–40 mm	**Organogenesis** From week 6 on, the sense of touch is the 1st sense to be developed before seeing and hearing is possible. Shortly afterwards the **embryo is able to hear** the mother's (or twin's) blood circulation and intestinal noises. From week 6 on: **muscles emerge, first active movements. Muscle training stimulates the creation and linking of nervous cells.** From week 7 on, the muscles distribute Dopamines and Endorphins. **Emotions can now be suppressed by contracting the muscles, which weakens the perception**. From week 7 on the gonads of future boys produce Testosterone. **Fingers** and **hands** come into being before the feet develop. Eyelids are shut now. **The Babkin-reflex** (Blomberg, p. 115) starts to develop. If later in pregnancy it touched the palms of the hands it might bend the head forward, open the mouth and make sucking movements **to train for later breast-feeding**. This reflex continues for 3–4 months after birth. In case the newborn does not suck properly, the palms of the baby can be massaged to stimulate the Babkin-Reflex. **The fear-paralysis-reflex** as a stress-reaction is now being established as a very early retreat-reflex. If the pregnant mother experiences a lot of stress in the first months or the unborn child is threatened, it might stay in a **state of freezing and immobility** for most of the time (DVC, Porges, 2011).Or in a **state of constant stress** and adrenalin and cortisol (SNS) is poured out (Blomberg, p. 109).

3rd month	Foetal period	–9 cm	Legs and arms grow. Taste-buds can be seen in week 10. In week 11 **the Plantar-reflex** develops as an early grasping reflex and **trains the movement of the toes to be able to cling on to someone**. Like the Babkin-Reflex, another grasping reflex, it also supports the later breast-feeding. From week 12 on the **sex is recognizable** and identifiable. The organs come into being. First reflex actions and reactions occur after being touched (Abortion, abortion attempts, Amniocentesis in week 16/17). **The Moro-reflex** starts to develop and should be fully formed in week 30 (Blomberg, p. 113f.). It is also triggered by loud unpleasant noises, quarrels, fighting, disagreeable or threatening touches like being boxed or hit from the outside. The yolk bag disappears since liver and spleen function now. They produce their own blood corpuscles and can detoxify the blood now without having to send it all back to the mother. From week 14 on, thumb-sucking is practiced. The grasp-reflex is now beginning to be developed.
4th month		–16 cm	**Bones** are perceptible, **joints** are created. Swallowing reflex and sucking reflex. A separate closed blood circulation system allows some more self-regulation. The whole **5 million eggs are developed in the female foetus**. From week 16 on **noises and sounds** from the outside world can be perceived.
5th month		–25 cm	Hair growth: Fur-like Lanugo-hair covers face and body. Mothers can now feel the movements of the foetus. The beginning of the **myelination**. **Until the end of month 6 all neurons (100 billions) are built. Especially the part for perception is completely active**. Parts of the limbic system are now developed and are networking. The **amygdala** is fully functioning now (LeDoux 2002). From week 24 a rapid increase of **myelinated vagal fibers** (**Ventral Vagal Complex**, VVC, Porges, p. 122). After birth the linking of the neurons continues in all parts of the brain. **The synaptogenesis of the cortex only begins after birth. Postnatally it takes 6 - 8 months until the orbitofrontal cortex functions fully** (Herman 2010, p. 90). In week 18 **the asymmetric tonic neck-reflex** (ATNR) starts to develop. When the foetus turns the head to one side, the arm and leg are stretched to the same side whereas at the other side of the body the arm and the leg bend. This releases kicking movements and is a **training for the birth-process** (Blomberg, p. 114). **The ears are now completed, the ability to hear is entirely formed.**
7th–8th month		–35 cm	Via hiccup in the last three prenatal months **the diaphragm** is trained. In month 7, specialization is already completed. From now on the embryo only puts on weight. Communication between mother and unborn functions via **right hemispheres** (A. Schore). The eyes are open, lungs work but are still immature. The foetus is viable.

38th–40th week			Birth: *"The human infant is not born with a completely functioning myelinated vagal system. The mammalian vagus is only partially myelinated at birth and continues to develop during the first few months postpartum"* (Porges, p. 122). If there are no medical interferences the foetus defines the exact time of leaving the womb and pushes itself off the contracted stable wall of the uterus **by the toes. In fish-like, involuntary movements it starts the journey.** (The more the unborn had to protect itself, the less mobile and vigorous it is during the birth-process.)

3. Examples of Circumstances Causing Prenatal Trauma

"... the amygdala is fully functioning in the second half of the prenatal period, and if the unborn baby perceives through sensory activity a situation threatening survival, this will be stored in his amygdala. Moreover, if the mother perceives a threatening situation, the amygdala nuclei of the unborn baby will also register the perceptional context along with the mother's physiological response" (LeDoux, in: Janus, *Die pränatale Dimension in der Psychotherapie*, 2013, p. 160).

- Abortion-attempts
- Longer duration of strong ambivalence and feelings and thoughts of rejection
- Chronic anxiety and stress
- Severe depression
- Premature uterine contractions (the earlier, the more frequent, the more life-threatening they are)
- Longer use of tocolytics (meds to suppress premature labor)
- Violence and quarrel in the partnership or in the close surrounding, (e.g. screaming, being boxed, kicked, pushed)
- Natural catastrophies, accidents, shootings, terror, war
- Separation of the parents
- Medical problems like Gestosis, Eklampsia, Preklampsia, etc.
- In-utero death of a twin
- Lack of food
- Abuse of alcohol, medicine, nicotine, drugs (Frank Lake, The Toxic Womb Syndrome)

3.1. Abortion-Attempts

Abortion-attempts are always very traumatic experiences and result in the deepest form of schizoid frozenness. In panic the heart begins to beat fast, then the tachycardia ceases, the embryo shies away, and in a fear-paralysis-reflex falls into total numbness by activating the dorsal vagal complex (Porges, p. 292). The embryo stays there and has to defend against the danger from the outside, against its own panic and the fear of being attacked again or of being caught when finally coming out.

Possible consequences:

- deep-rooted coldness
- severe depression
- feelings of profound worthlessness
- reduced vitality and weak perception of the body
- feelings of not belonging to this world
- psychoses, paranoia
- strong feelings of mistrust, unsociableness, even Autism (Dowling 1997)
- hospitalized movements
- uncontrollable fits of aggression
- chronic pain-syndrome
- feelings of being threatened in human closeness (Lowen, *The Betrayal of the Body*).

3.1.1. Case 1

"A sky-scraper stands in the middle of a torrent. I live on the first floor and can only get there by boat. I think: For god's sake that's where I should live, I need to escape at once. The torrent gets worse, it will sweep me away. How can I ever manage to reach the shore?"

"Someone hands me a little lifeless child with terrible strangulation marks on the throat and, horrified, I think by myself: How can people do this to a child?"

A woman of 50 years, a mid-wife herself, had been in therapy with me for almost 6 years.

She came because of her hypertension, her repeating nightmares, her severe depression and her being incapable of working. In her marriage with her much older husband she felt "hemmed" in as if she felt hindered to breathe. She was the 6th child of seven, with two miscarriages right before her. It was not certain whether the mother had on purpose induced abortion with them. But during therapy she found out that this was

certainly the case. From the start she remembered her dreams clearly and gradually it became obvious and was later coldly confessed by her mother that she had tried to get rid of her several times by using knitting needles. What the mother did not know at that time was that she had expected twins and when one embryo left, she stopped further efforts. My client later experienced herself in utero as being a frozen foetus in an awful conflict: She was afraid to stay and afraid of coming out.

Actually she was born 3 weeks too early via an emergency-cesarean with the umbilical cord twofold around her neck. Her mother often told her that her birth was the most dramatic one of all of her births, because she suddenly had started to bleed and for a long time this bleeding could not be stopped. When born, my client was blue and unable to breathe. Both mother and child were in mortal danger and were separated from each other. The doctor and nurses grabbed the newborn by the feet, held her underneath cold water and kept hitting her on her back and her buttocks until she finally cried, which she did more or less for the following three days and nights. Fortunately her grandmother sometimes turned up and carried her around because her mother could not care for her.

When the baby was three months old, her mother arranged an operation for her, because my client's spider naevus (lesion) at her throat annoyed her. This operation was not completely successful and had to be repeated at the age of six months. Both operations were undertaken without any narcotics. From then on she was described as a very quiet and well-behaved baby and child.

When she was older she tried in vain to win her mother's love by helping her as much as she could. Fortunately her warm, accepting father, an architect like her husband, was, besides the grandmother, a compensation and without the two of them she *"... might have died very soon"*.

3.1.2. Case 2

"I crawl up a steep hill to a tower on the top. Inside is a hole and I climb down, head first along a narrow channel until I come to a little cave. Suddenly a knight attacks me from the right hand side with a lance, then another one with a lance from the left hand side. I press myself against the wall and try to hide."

"I can see myself in an igloo standing in an artic landscape. I'm all alone with no-one to turn to. It is terribly cold and I have no idea how to survive in such coldness."

In 1986 at the age of 32 a very pale, haggard psychologist *"full of fear, hate and rage"* came into my office looking more dead than alive. The above dreams he called his

"standard dreams of my childhood" with no idea what they meant. During therapy he realized and felt deeply that, *"already there had I lost all hope, all optimism, all joy and trust in life"*.

He had been living in almost total isolation thus far, with only one student-friend and regular visits to his family. He had never had any close contact with women and it took all his courage to come to me now, because he *"could not stand life anymore and was considering suicide."*

His parents had been very poor and lived together with the mother's mother in one flat.

He was the first child and the mother was very ambivalent about her pregnancy. Since the grandmother and the unemployed father who had a drinking problem and later became an alcoholic, were definitely against a baby, she and her mother had tried for several times to get rid of him by using knitting needles. When they did not succeed, his grandmother finally said: *"Let us stop, somehow we will manage to get the baby through."*

During his birth his mother fell into a coma and stayed there for three weeks. Every four hours the nurses took him to her and thus he was at least breast-fed for a while, even though she did not notice him and it felt very embarrassing to him. His mother needed months to fully recover and his grandmother cared for him most of the time.

When he grew older he became a very beautiful child and his mother started to cuddle him, which ended abruptly when his brother, who was four years younger, was born. The economic situation had improved and they lived in their own flat now.

In recurring dreams he was haunted by war-scenes and murderers chasing him. At the beginning of therapy his only safe place was a space-shuttle far away in the universe with at least a direct talking-line to me. In 1990, after 4 years of therapy he left because he had finally got married and his wife and he expected a child. He returned 10 years later, just separated and stayed a few months to get over it. In the beginning of 2013 he showed up again, because he and his girlfriend, a warm sociable teacher, planned to live together after five years of acquaintance.

3.2. Chronic Anxiety and Stress

"In comparison to most of the other mammals the placental contact between mother and child is especially strong. Hormones, medications and toxic substances need only a few seconds until they flow through the mother's blood circulation into the placenta. For a

short time the placenta can even function as a buffer against them, but if the distribution continues they reach the unborn" (Terence Dowling, seminar 2006).

In cases of chronic anxiety and stress the unborn is flooded with a lot of maternal stress hormones like adrenalin, cortisol and noradrenalin, which all stimulate the sympathetic nervous system and generate tachycardia. *"In a tense environment the blood of the foetus rather flows to the muscles and the brain-stem to supply those parts of the body that are necessary for a life-saving reflex-behaviour. Owing to this protection reaction less blood flows to the intestines and the stress-hormones also suppress the function of the basal forebrain"* (Lipton 2007, p. 174). For a while the child can regulate itself but if the situation continues the child suffers under constant stress and the exhausted stress-system can cause infections, since the immune system is weakened (Bauer 2011, p. 47, p. 117). This can later lead to various diseases like colitis ulcerosa or Crohns Disease. Usually these babies, thus made insecure, are very anxious and clinging and tend to cry a lot.

3.2.1. Case 3

A professor at the age of 57 came to see me after 700 hours of psychoanalysis, because some of his most annoying symptoms like burn-out, hypertension, chronic sinusitis, bronchitis and the inability to feel well when alone had not changed. The analysis had concentrated on the early parental divorce and on his violent stepfather. He had gained a lot of understanding for himself, but still felt that he could not relax and feel comfortable in his own body.

He was the first child of a mother who had tried to chain her weak, latent homophile husband, a gifted painter, to her. When it became clear that he would never really love her and be a responsible father she regretted the pregnancy, and was in constant worry that she might not manage to raise a child all by herself. He was born two weeks late via an emergency-caesarean and was covered with infantile eczema and furuncles (boils). His mother refused to hold him or nurse him and only every now and then gave him his bottle. Whereas, she left the clinic within two weeks he stayed there and was finally put into a dark small room *"to die"* where his father found him two weeks later. He took him to a university hospital where he was treated with antibiotics for five months. His mother had gone back to work and never visited him and his father came rarely.

After he had realized that his symptoms had a lot to do with the suppressed feelings of the unborn and newborn, the symptoms gradually vanished and he started to be more considerate with himself by doing sports, eating less food as well as more

wholesome food and working less. He is now in the middle of a dramatic journey back to his earliest injuries and his deep desperation and frozenness.

3.2.2. Case 4

A woman in her late thirties, a doctor and therapist herself, was sent by a colleague, who felt that she needed body-oriented therapy and not merely talking therapy. Literally, since she had moved into the house of her current husband, (where he had lived with his first wife who had left him against his will) she had developed a grave colitis (Crohns Disease) with sporadic heavy bleeding. Shortly before I first saw her she had been in hospital and the doctors now advised an operation to remove the infected parts, which scared her a lot. She described herself as being under stress very easily; even the packing of her luggage to go on holiday stressed her awfully.

She was the second child of a young, insecure mother who had lost her son two years ago during birth because of an iatrogenic mistake. During her second pregnancy, being still traumatized by the loss of her beloved son, she felt a lot of panic that she might also lose this child. The mother later confessed that she was afraid of loving my client and building a strong prenatal connection to her as a protection for herself.

In many dreams and prenatal exercises my client remembered this period as a time of *"complete loneliness"* and her body as being stiff and immobile. Being born she met a very sad and exhausted mother who for three weeks put her away in a children's home at the age of three months, because the parents found that they needed to go on holiday. When the parents fetched her *"she was a completely different baby, very thin and fragile"* since she had not really wanted to eat and additionally had suffered from diarrhea.

Daring to gradually feel the connection between stress and her stressful and sad beginning of her life helped her to recover without needing any operation so far. And even though she is not yet totally cured the bleeding has completely stopped.

On the deepest level of her prenatal time she found the parallel between her mother and her husband. For both of them she was *"the wrong person"* and her mother *"would have definitely preferred if her son had survived instead of me."* And her husband would have liked to still be with his first wife. After trying couplse therapy she finally moved out and is now divorced. This is a step the unborn could not take!

3.3. Lack of Food During Pregnancy

The growth and the development of the child can be lastingly affected by the lack of food during pregnancy. It can be seen as the deepest form of orality. In case this

lack occurs during the first three months of the pregnancy, the development of the organs could be influenced and they could be irrevocably undersized (Nathanielsz 1999).

Consequences:

1. The liver cannot regulate the cholesterol level sufficiently, which can cause chronic hypertension and arteriosclerosis.
2. The pancreas does not produce enough insulin to assimilate normal amounts of blood glucose. Diabetes is likely to be developed.
3. A general risk to suffer from overweight and cardiac and circulatory troubles in later years.

3.4. Alcohol Abuse: An Intoxicopathy

Besides nicotine, alcohol belongs to the most damaging poisons during pregnancy. Each year about 10,000 babies in Germany are born with physical or mental damage. 2,000 of them suffer from severe and irrevocable defects. The pregnant mother's consumption of alcohol is far more often the cause of physical or mental harm in children than genetic diseases. Even small amounts of alcohol in the first three months of pregnancy can drastically damage the development of the embryo's optic nerve by reduction of the vitamin A level. Furthermore intoxication can lead to hypertension and renal insufficiencies. In severe cases, (which we usually do not see in our private practice) it results in deformities of the face (Downing, seminar, 2006).

In the second trimester of pregnancy alcohol can disturb the building of the nerve-cells whereas in the third trimester it can destroy the already existing neurons. In comparison to nicotine abuse enough blood reaches the unborn, but the blood is intoxicated so that the child has to protect itself and its liver must carry out heavy labour.

Physical Protective Measures: With the help of the contraction of the psoas muscles the unborn adducts its little legs to pinch off the groin. Thus the heartbeat is reduced and the child waits in a protective position until the level of the alcohol decreases and the dilution of the poison, (all of which must be processed through the developing liver of the foetus), starts. Gradually the heartbeat comes back to normal again.

3.5. Nicotine Abuse: A Deprivation-Syndrome

Nicotine is one of the most damaging poisons constricting the development of the body and the brain. Even a relatively small dose of this poison (about 6 cigarettes a

day) is enough to vitiate the growth and the brain development. Postnatal hyperactivity is seen in this connection (Dowling, 1997).

If the pregnant mother had been smoking or was forced to chronically smoke passively the risk of having a still-birth or a preterm birth or a caesarean rises. The newborn babies are usually lighter, smaller and have a diminished circumference of the head. More often they suffer from allergies, asthma or infections, more frequently they later become addicted to tobacco and/or overweight, and can show developmental retardations and problems concerning learning and their behaviour (Dowling, 1997).

The unborn inevitably has to "smoke" with the mother causing the following results:

- Shortly afterwards the concentration of nicotine increases in the blood of the mother and the unborn.
- The supply with oxygen and nutrients deteriorates.
- The nicotine causes stress in both organisms and the blood pressure rises which leads to tachycardia and the veins and arteries get tighter and thus impede the blood circulation. The blood first supplies the brain that is essential for survival and flows away from the abdomen and the extremities, which get cooler and less supplied with blood.
- Even the mother's wish to smoke provokes tachycardia in the unborn.
- The carbon monoxide creates an oxygen deficiency that can lead to a so-called "false suffocation" and the organism is in a state of alarm and distributes a lot of adrenalin.

Physical Protective Measures: The unborn can better protect itself from the poison in comparison to alcohol, the anoxia, however, is very threatening. By an accelerated heart beat the baby pushes the blood out of his own blood circulation back to the placenta and thereby it has to do excessive work that can tense or even enlarge the heart. This can later result in the feeling of "I have to work to survive" (See Case 5).

3.5.1. Case 5

The 46 year-old teacher, born in Lithuania, came to me because of burnout, constant stress and her bad contact to her only daughter. Her mother worked as a medical doctor and midwife in a clinic. Twelve times she herself had successfully completed abortions via a suction apparatus when she finally *("I have no idea why")* decided to keep my client alive. Relentlessly, she smoked *"2–3 packages of cigarettes every day"* and on weekends she liked to drink heavily. My client was born with an enlarged heart and hepatitis and a *"very tense body"*. She used to cry for hours and only the grandmother could calm her down. For months in therapy I had to appease her be-

cause she was in a state of chronic hyperarousal and stress. She could hardly be still for a while and relax and as a mother she used to be very demanding, impatient and even aggressive toward her own daughter. It took us a rather long time to realize how early these patterns had been installed and how difficult it was to change them.

4. Examples of Perinatal Trauma

"Birth is the greatest challenge to human survival … (it) … disrupts the fetus's dependency on maternal physiology and expels the fetus from this secure environment" (Porges, p. 83).

- Premature birth
- Umbilical cord around the neck with anoxia
- Cyanosis, Blue-baby-Syndrome (or other reasons)
- Cesarean Section
- Breech delivery
- Suction cup delivery
- Forceps delivery
- Precipitate delivery
- Placenta praevia
- The use of ebolics during birth
- Postnatal separation without any bonding because of an amniotic liquid aspiration or other medical problems of the mother or the baby

4.1. Cesarean

Primary cesarean: 5 to 10% and planned before birth because of a medical indication and without any uterine contractions. Usually done under a general anesthesia or less often under a peridural anesthesia. (At first the mother is 'gone' and shortly afterwards the unborn is also numbed.)

Secondary cesarean: Unplanned and suddenly necessary because of complications during the birth process. More often the child here can experience uterine contractions for a while. Usually done under peridural anesthesia.

Wished cesarean: Planned on an appointed time without medical reasons and without any labour pains. Tendency increasing.

In the USA caesareans are the most frequent operations and the rate lies between 25–50 % depending on the specific clinic (Emerson, 2013, p. 90).

For the mother the big belly wound means pain and a long scar and the risk to get a thrombosis and embolism and for the child it can also have grave effects, such as the following:

Respiratory problems: Since there is no body-massage as during a normal birth to press the amniotic liquor and/or the meconium out of the child's lungs it can come to an amniotic liquor and meconium aspiration, which often results in lung infections and breathing problems. A Swiss study showed that *"a cesarean increases the risk for asthma in comparison to a normal delivery about 80% ... and that the rates for cesareans and asthma are rising in parallel in the last decades" (*RNZ Wissenschaft, p. 15, December 2008).

Missing physical experiences: The numbed mother cannot encourage the baby. The first very important full body massage and the experiences of one's physical boundaries of a vaginal birth are omitted. Furthermore, the child is bereaved of the experience of being active and effective and it cannot co-determine the time of the leaving. Involuntarily, mechanically and often too early he is quickly taken out of his warm abode.

Nursing problems: This frequently occurs since the milk is produced one day later than normally and the mother is weaker and more strained.

Bonding disturbances: The intoxicated mother needs longer to recover and be really there for the baby. Sometimes, due to medical complications, a separation is necessary.

4.1.1. Case 6

"Nazi soldiers abruptly and violently open the door of my room. They give me no time to get dressed or pack anything. They grab me firmly, I have to leave at once."

Three years ago a young teacher, suffering from allergies, chronic sinusitis and severe asthma combined with fits of panic, came to see me. Like her older sister she was born via a planned cesarean together with the third daughter, her twin-sister. Unfortunately she had swallowed too much amniotic liquid and meconium and had difficulties breathing. Whereas her mother stayed with the other twin, she had been taken to a special hospital and had to stay there for two weeks. Her mother never visited her and she developed pneumonia. During therapy she realized the relationship between her early suffering and her actual disease and the panic. She lost her fear of dying and after undergoing several respiratory infections is now almost completely healthy. Since then she never again had any life-threatening asthma attacks.

During the therapeutic process she became aware of the fact and expressed it with wonder that, *"my inner child had not yet realized that it was already born without any birth-massage and without a loving touch afterwards."*

4.2. Breech Delivery

The baby does not glide with the head but with the pelvis down towards the birth channel, while the legs are folded up and cover the body and the head. The baby thus finds itself in a very difficult situation. The more it tries to fidget and follow the natural need of the legs to move and to push against the uterus wall the worse it gets and the baby experiences helplessness and impotence. If there soon is competent help this might not be necessarily traumatizing, but if this is not the case the little head and the vertebra are submitted to high pressure and a strong drag force. Frequently the baby gets stuck and anesthesia has to be given to the mother and she loses the contact with her baby.

Typical later consequences: Feelings of anxiety and impotence, drug abuse, back pain, spine disk problems, blockage of the sacroiliac joints. The pelvis area is often very tense which can cause cystitis and myoma. The following is a case involving breech delivery.

4.2.1. Case 7

"I'm sitting in a wheelchair and I desperately want to be able to walk, but no matter how hard I try I cannot move my legs. Usually I wake up in panic."

One reason to come into body-oriented therapy was this repeating dream of a forty-two year old nursery-school teacher. Besides that she mentioned that she could not go to sleep without having drunk 6–8 bottles of beer, that she was afraid of the darkness, but also afraid when it was too bright and that she could not go and visit her mother in the hospital, because of panic attacks approaching the building. She could not explain her symptoms, since she was a loved child and had a rather good relationship with her parents.

When working deeper with her dreams it turned out that the person in the wheelchair was not yet born. When she asked her mother she told her that she was a breech delivery and had been stuck in the birth channel for almost an hour (and) three doctors, and three nurses had pressed and pushed against her belly and the mother's pain had been so unbearable that to her greatest relief she finally had received laughing gas and did not remember anything else.

Gradually and after a lot of preparatory bioenergetic work with her legs, she needed several healing re-experiences of her birth until the panic lessened. After two and a half years of therapy she left me and had no more inclination to drink alcohol to ease the pain of the baby (she had been) as the laughing gas once did.

4.3. Suction Cup Delivery

The most frequent vaginal-operative delivery is when the unborn gets stuck in the birth canal, the heart rate decreases or the mother cannot press. By generating a vacuum the baby is pulled out with the suction cup tight around his skull. Sometimes this works very well within a relatively short time with little risk for the mother and the child, but in difficult cases complications can be quite serious.

Possible consequences for the baby:

- Swelling and/or strong deformations of the head
- Hematomae and injuries of the skin
- Kiss-Syndrome (Atlas-Axis induced asymmetry)
- Panic with tachycardia and mortal fear

4.3.1. Case 8

A very beautiful 34 year old single woman came to me with the feeling *"I am ugly, I am not okay, I have nothing to say, nothing to determine, I am afraid of closeness and I would need my own slow tempo but never have it. I feel completely numb in my body."* Her mother had had eye-tuberculosis as an adolescent and when she gave birth to her first son, my client's 3 years older brother, the scars in her eyes burst and she had been blind for several weeks after delivery. She was very afraid to receive a second child, but her husband persuaded her and with constant worries she became pregnant again. During the second birth she was not allowed to press at all because of her eyes and my client was dragged out via a suction cup. *"In total shock and way too early"* as she found out later in therapy, she entered the world. Her freezing state that could have been released by a loving comforting mother was even aggravated because her cool and unempathic mother refused to hold her, because her *"head was elongated and strewn with blue-green hematomae and swellings."* The nurses took her away for several days, because the mother could not bear the sight of her.

5. Therapeutic Procedure

Stabilization

"The injuries can only be healed in the same way they were primarily generated: In the relationship with another human being" (Herman 2010, p. 90).

- Verbal anamnesis (recollection) including the time of the mother's pregnancy and the birth, without dramatizing, just registering
- Physical anamnesis
- Establishing contact and building a trustful relationship in a safe, warm and welcoming atmosphere
- Mental reinforcement
- Help for self-help and learning of techniques to calm the amygdala
- Grounding in mother earth and one's own body
- Introducing physical relaxing and self-strengthening exercises
- Focus on the resources and inner healing power and self-regulation
- Encouragement of working on one's resilience
- Gradually enhancing the breathing
- Working with the right distance and closeness and – if allowed – with touch and holding
- Grounding in the therapist's body, especially when the standing position does not feel right or seems impossible and there is yet no pleasant and secure place to find in oneself
- Mindfulness based stress-reduction, sensitive awareness exercises
- Anxiety and immobility must be uncoupled, methods to come out of freezing and dissociation must be learned
- Dream analysis without interpretation from the therapist's side. The client will and can find his own answers.

Re-Experience/Trauma-Reconstruction

"Un-discharged toxic energy does not go away. It persists in the body and often forces the formation of a wide variety of symptoms such as anxiety, depression, unexplained anger and physical symptoms from heart trouble to asthma" (Levine 1997, p. 20).

Since the prenatal and early child does not have a developed prefrontal cortex and hippocampus, which is only fully mature at the age of three years, these early events and injuries can not be understood by cognition, but they will be stored in the amygdala as wearing emotions and symptoms (Herman 2010, p. 60).

To communicate with the early traumatized prenatal or perinatal child one has to speak the language of the brain stem, the limbic system and the body-memory. A right hemisphere to right hemisphere dialogue between the therapist and the client should be established (Shore, 1994).

When dreams, physical postures or memories show up that indicate pre-or perinatal trauma (sometimes they are there from the very beginning) the process step by step goes back to the womb-time and the birth experience with the help of:

- Working with dreams
- Learning to differentiate between the adult and the child, the therapist and the original caretakers
- Understanding the symptoms as the language of the wounded child
- Carefully developing analytical understanding and the discovery of the why and when and what happened
- Fingerprint diagnosis (Dowling, Nathanielsz)
- Diving deeper into one's sub-consciousness and one's inner world by bringing the client into an alpha-state (Place of super-learning, Lipton, 2007)
- Technique of guided imagery in an alpha-state. Without any information about the time in utero or about the birth one can precisely perceive and feel what happened
- Re-living and re-experiencing the time in utero and/or the birth in a healing new way
- Sometimes literally going back into a symbolized womb, covered underneath a darker sheet, and with the legs grounded in the therapist's belly. In a dialogue with the unborn we can find out how it really felt, why it may-be did not want to be born or in some cases why it had a reluctance to settle down in the womb of this specific mother at all. The client must deeply understand and learn to believe, that the danger is over, that if he now moved and lived fully in the womb and in his life and if he decided to be finally born there is no cold or disinterested or disturbed mother anymore, but that he will now be received and accompanied by a warm, welcoming therapist and the grown-up part of the client himself.
- Prenatal breathing
- Specific rhythmic breathing exercises
- Specific prenatal rhythmic physical exercises for the integration of the not integrated primitive reflexes. These rhythmic exercises also dampen the sympathetic tone, promote activation of the emotive, social vagus (Porges, 2011) and a stimulation of the brainstem. They are done while the client is lying down and the therapist moves the client rhythmically and softly, beginning with the feet, then the knees, hips, chest and head.

  This specific passive rocking simulates the mother's movements, heartbeat and breathing. By activating the brainstem, higher parts of the brain structures are also positively influenced and can maturate (Blomberg), 2011); the limbic

system can thus be soothed, that supported fight, flight or freezing behaviours (Porges, p. 190); and the HPA axis activity can also be inhibited.

- Establishment of the natural, involuntary birth-reflex that shakes the freezing loose and helps to prepare for the re-living of the delivery
- Finding out which primal instinctive reactions had not been carried out and have to be performed now
- Learning to express and integrate deeper feelings
- Understanding and integrating that one is no longer trapped inside a cold or rejecting or intoxicated home
- Several re-enactments of the birth process are usually needed until the clients really feel their own efficiency and potency and until they can realize that they are now able to manage to be born in a normal way with a now strong and grown up body
- Learning to find completely new solutions
- Understanding that the prenatal and just born baby had only very few possibilities to react, and could neither flee nor fight and that this is not the case anymore
- The therapist should go into resonance and feel what the baby felt without being overwhelmed and should encourage and comfort the inner child (Bauer 2011, Levine 2011, p. 65).
- The linking of the pre- and perinatal child's brain-stem and limbic system with the cortex and prefrontal cortex of the grown-up gradually has to be strengthened to help alter the strongest and earliest convictions and to better understand and finally accept the most deeply rooted experiences and perceptions of this period of life and to mentally and physically realize that it is all over.

6. Conclusion

Never again in our life will we be a part of someone else, will we be so deeply connected to someone else, so fundamentally influenced by someone else, never again will we be so vulnerable and dependent. Even before looking into the eyes of our mother we 'know' a lot about her personality, her strength, her health, her feelings, her sexuality, her attitude and especially about the quality of her bonding and loving feelings toward us. Our personal story starts long before we are born and if this first bonding was sufficiently optimal and positive, our birth-experience uncomplicated and our perinatal time with the mother was warm, loving and undisturbed, it provides us with a very important first secure base in this world. In cases where this did not happen it is inevitably necessary to go back to the very be-

ginning of our earliest and most forming injuries and imprintings, otherwise they will never be annihilated.

The prenatal and perinatal period creates the first important foundation and, of course, this period is just the beginning of a long story, but a beginning that can make a permanent impression on our entire later life. As Thomas Verny put it: *"Consideration of pre- or perinatal traumas without an exploration of subsequent traumas is as incomplete as psychotherapy that neglects the pre- and perinatal period"* (Verny 2013, p. 203).

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