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Research discoveries from diverse fields over the past two decades have increasingly impacted the clinical principles for effective Body Psychotherapy. Many have provided scientific evidence for the efficacy of our current practices; some are pointing the way to new principles for our art and craft. This research is converging to suggest new paradigms regarding our earliest human development and what it takes to raise relational, creative and resilient adults and how healing can occur throughout the lifespan. Research and clinical experience from seemingly disparate fields of epigenetics, developmental psychology, affective neuroscience and brain imaging studies, polyvagal theory, attachment theory, and prevention and healing of trauma are providing us new ways of considering mental and physical health. Particularly highlighted is the quality of the infant-caregiver relationship and its life-long impact on neurological development, self-regulation, the creation of mental models and the capacity for relationship. (Bowlby, 1969, 1988; Ainsworth, 1985; Beebe & Lachmann, 2002; Fonagy & Target, 1997; Fonagy et al., 2002; Lyons-Ruth & Jacobovitz, 1999; Perry, 1999; Porges, 2011; Schore, 1994, 2003, 2012; Siegel, 2012a, 2012b; Stern, 2004; Tronick, 2007). It is important to note that we never want to place blame on parents or the medical system, in general. Our goal is to educate and assist in the healing process, given what we know now.
Increasingly, research and clinical practice are looking even earlier than post birth and infancy for the foundations of health and dis-ease and for practices to prevent and heal maladies throughout life. Much of this research demonstrates that our prenatal experiences lay the foundation for brain development and mental health or illness (Kaplan, Evans, & Monk, 2007; Lupien et al., 2009; O’Connor et al., 2003; O’Connor et al., 2005; Shonkoff, Boyce, & McEwen, 2009; Talge, Neal, & Glover, 2007; Van den Bergh & Marcoen, 2004; Van den Bergh et al., 2008). It is also well established that as humans we are particularly vulnerable to a broad range of effects during the prenatal period (Nathanielsz, 1999; Thomson, 2007; Van den Bergh et al., 2005; Vergy & Weintraub, 2002). Prenatal and perinatal psychology has been creating and coalescing research and clinical practice in this arena for decades. Given that, in Body Psychotherapy, we know that the body records—consciously or unconsciously—every experience and that this experience forms the foundation for later development, it follows that prenatal and perinatal psychology provides a significant foundation for the practice of Body Psychotherapy (Juhan, 2003; Rand & Caldwell, 2004).

This chapter presents a cursory look and invites further exploration of the effects of our earliest development, including relationships and environment, with the hope that it might enhance your clinical perspective of the multi-faceted and trans-generational influences and provide support for new avenues of healing. In addition, it is imperative that, as clinicians, we continue our own healing process and apply these principles first to ourselves and then to our clients.

**Prenatal and Perinatal Psychology Definition**

Prenatal and perinatal psychology is commonly defined as the study and clinical practice relating to our earliest development to include pre-conception, conception, gestation, birth, post-natal experience and the infant’s first post-natal year. Pre-and perinatal psychology considers factors that contribute to optimal beginnings as well as aspects that may relate to stress or trauma patterns that could challenge healthy development. Prenatal and perinatal psychology offers best practices to ensure the most favorable outcomes as well as therapeutic interventions to resolve early dysfunctional patterns and trauma in infants, children and adults (McCarty & Glenn, 2008).

Also included is the intergenerational transmission of early imprints, meaning that parents’ foundational experiences and their mental models relating to themselves and the world,
create the template from which they relate to others, including their infants and children (Siegel, 2012a). We also know that parents who resolve their own early traumas help to give their babies optimal beginnings and a legacy for a lifetime of health.

This interdisciplinary study of prenatal and perinatal psychology provides an understanding of how experiences during this critical period impact lifelong patterns of physical, emotional, cognitive and social development. It includes the experience of the family system and other caregivers as well as the environment. Our first experiences – energetic, cellular, and relational – form the foundation of our physical, emotional and spiritual existence and therefore hold the “framework” of our being: memories, mental models, our capacity for self-regulation and relationship.

A Common Tale

Many pre- and perinatal practitioners discovered the importance of our earliest experiences from our clients. In the late 1970’s and early ‘80’s I used two modalities that often elicited discoveries of very early trauma: one was Ericksonian hypnotherapy in which body sensations were key; and the other was body-centered Gestalt therapy. When we worked with Gestalt principles, on the floor surrounded by lots of pillows, the work was more experience than words. As the client’s focus became more internal, we would say, “Let your body do what it knows how to do” and, supporting each movement of the body, very often, the client would execute what we later discovered was a birth sequence. In hypnotherapy sessions, we would traverse back in time and follow the body sensations, with the suggestion to, “Take us back to the source of this difficulty”. Very often, clients would have something that seemed like a pre-birth experience; for example, a memory of parents fighting, mom being afraid, and an early decision to take care of her, or clients would spontaneously describe and/or re-experience their birth.

The session with a client, whom I’ll call Ruth, catapulted me into a search for deeper understanding of these phenomena: it is a graphic story and yet illuminates how our very earliest experiences can affect our physical, mental and emotional capacities. Ruth came to see me because, although she and her husband had a close relationship, she had become increasingly anxious around sexual encounters, and in fact, her discomfort with being touched had escalated to the point that they had stopped making love altogether. I discovered that her parents had had a solid, caring marriage; she had little trauma growing up and no evidence of sexual abuse.
During a hypnosis session, her only instruction was to, "Take us back to the source of this difficulty". In a very deep trance, she began to wince, shake and make distressing sounds. I asked her if she was okay, and or wanted to stop. She indicated that this was important and she needed to continue. Then, in a soft and halting voice, she described a horrific scenario: "It's dusk... I'm walking down a cobblestone street... there's four soldiers... Oh, No!..." Her body began to writhe and through her tears she made distressing sounds. Again, I asked if she was okay, and she indicated that she needed to continue. Ruth was obviously re-living a dreadful experience. Upon inquiry, she did not remember such an experience and, in fact, had an aversion to even watching scary movies.

I knew Ruth was going to visit her mother over the weekend and so I suggested, if she was comfortable, that she might share her experience with her. The following week she began the session with this account, "On Saturday morning, mom was making tea for us and I began telling her my experience on the cobblestone street and the four soldiers. She blanched, dropped her tea cup, sat down, and with tears in her eyes, told me this story:

Just after I discovered that I was pregnant with you, I went back to Europe to visit some relatives, and one evening went for a walk down a cobblestone street where I was approached by four soldiers in uniform and they raped me. It was terrifying. I was so humiliated and ashamed that I ran back to my aunt’s house, took a hot bath, went to bed, and shook for a long time. I never told anyone. Your father doesn’t even know."

In therapy, we dealt with the trauma that Ruth had suffered as a result of her mother’s assault, and she was able to resume a loving relationship with her husband. After working with Ruth’s experience, I began doing some research and looking for my own answers to the questions that this story evoked, and I found that other clinicians were making similar discoveries, and in fact, a whole movement was underway, both in Europe and the United States, to investigate the effects of our earliest experiences.

**The Evolution of Prenatal and Perinatal Psychology**

I first encountered Thomas Verny’s (1981) book, *The Secret Life of the Unborn Child*, that synthesized findings from many fields of inquiry to suggest that the prenatal child is conscious, feeling, remembering, and is very affected by its environment. And, in fact, he espoused, "birth and prenatal experiences form the foundations of human personality" (p. 118). Delving more deeply into the prenatal experience, I uncovered Otto Rank’s (1952) writing, "The Trauma of
Birth" (first published in 1923), in which he suggested that adult neuroses and character disorders originate in the anxiety related to the birth process. Since then, Nandor Fodor (1949) and later Francis Mott (1960) headed the modern investigation into prenatal experiences. Soon after reading Verny’s book, I also encountered the professional organization he founded, now called, ‘The Association of Prenatal and Perinatal Psychology and Health’, and discovered numerous like-minded colleagues.

In taking a brief look at the development of this field, we see that several therapeutic modalities emerged during the second half of the last century including hypnosis, psychedelics, regression therapies, primal therapy, breath-work and process work. Influenced by the work of Rank, psychiatrist Stanislov Grof (1975, 1985) first used psychedelics in the 1950’s and later breath-work to explore human consciousness, which led to a conceptual framework for pre- and perinatal psychology. Also in the 1950’s, Frank Lake’s (1966, 1981) work, like Grof, began with psychedelics and later focused on a rapid breathing technique, and also focused particularly, on the first three months of gestation and on primal integration. Graham Farant (1987) resonated further with Lake’s findings, being quite specific about cellular consciousness, imprints from conception onwards and their lifelong effects.

Obstetrician David Cheek (Cheek & LeCron, 1968) and psychologist David Chamberlain (1988) began working with adults, using hypnosis to discover and heal experiences relating to birth. Arthur Janov (Janov & Holden, 1975; Janov, 1983) developed his ‘primal therapy’ that involved the reliving of early traumatic events, including birth. Alongside these methods, the 1980’s also saw the emergence of other modalities such as rebirthing (Ray & Orr, 1983); psychoanalytic techniques of Leslie Feher (1980), who emphasized the trauma of cutting the umbilical cord; and Martha Welch’s (1983) controversial ‘holding therapy’. While the work was initially focused on adults healing their earliest, often traumatic, experiences, William Emerson (1989), later Ray Castellino (2000) and Wendy McCarty (2000, 2004) focused on healing early imprints and trauma with infants and children.

Basic Assumptions of Prenatal and Perinatal Psychology
A basic assumption of pre- and perinatal psychology is that the developing prenate is a conscious, aware being, who is sensing, experiencing, and remembering from the very beginning and can therefore be affected by events even before conception (Lipton, 2005; McCarty, 2000,
2004) as well as *in utero* (Chamberlain, 1988; Janus, 1997; Verny, 1981). Circumstances, such as being unwanted, maternal anxiety, depression, experiences of loss, domestic violence, or states of extreme stress, create imprints on the developing child with lasting effects. These early imprints carry cognitive, emotional, relational, and somatic consequences, all evidenced into adulthood. Part of implicit memory, these experiences are largely unconscious, as are the mental models that ensue from them, and these ultimately determine our experience of safety, our self-image and self-scripts, and our expectations for how the outside world will perceive and treat us (Schore, 2003). This new synthesis of research and clinical experience invites us to re-examine our current practices to include an understanding of the prenatal and perinatal experience.

**Effects of Earliest Experiences**

As stated, research and clinical experience in prenatal and perinatal psychology have established the fact that our earliest experiences form the foundation of our sense of Self, our capacity to relate to others, and our resiliency throughout life. The core foundations of physical and mental health, emotional intelligence, and the ability to develop one’s capacities and talents are – we now believe – established between preconception and the first post-natal year (Chamberlain, 1988; Grof, 1975, 1985; Nathanielsz, 1999; Verny, 1981).

Given that brain structures, capacity for self-regulation, social engagement, productivity and resiliency are all built upon this earliest foundation, it benefits us to examine some of the tenets of the fields of epigenetics, embryology and affective neuroscience. Here, we discover some of the scientific building blocks of our individual development, and therefore of sound paradigms in prenatal and perinatal psychology, as well as in the practice of Body Psychotherapy.

**Epigenetics**

As we reflect on our earliest beginnings, and the creation of optimal health, it is helpful to consider our DNA, the most foundational aspect of our cellular makeup. Epigenetics informs us that our DNA, alone, is not the determinate of our physical structure, capacities, and vulnerabilities, but that gene expression is – to large extent – determined by the environment: this has the effect of ‘turning’ on or off certain genes. For example, from pre-conception onward, our biological systems assess the environment for safety or threat, and then choose responses to
sustain survival and optimal functioning, given the perceived circumstances and needs (Lipton, 2005; Rossi, 2002). There are implications not only for physical health, but also eventual mental health and/or mental illness. Levels of physical and emotional safety, anxiety, stress and depression all play a large part in the eventual outcomes of every individual, and these effects begin within our cellular structures, even before conception (Isles & Wilkinson, 2008; Szyf, 2009).

Evolutionary biology research also demonstrates that our earliest development, from conception through post-natal, "...‘reads’ key characteristics of its environment and prepares to adapt to an external world that can vary dramatically in its levels of safety, sufficiency and peril” including adjusting “set points” in key brain circuits (Shonkoff, et al, 2009, p. 2257). Harvard University’s National Scientific Council on the Developing Child published a review of the literature in their position papers three and ten (2005, 2010), stating that our earliest experiences can alter gene expression and affect long-term development and, as such, excessive stress, maternal or otherwise, disrupts the architecture of the developing brain.

**Consciousness**

Thirty years of international clinical research supports the ancient knowing that we are conscious, aware, beings, and also we are learning and connecting from the beginning of life (Chamberlain, 1988; Hamilton, 2004; McCarty, 2000, 2004). This research is helping us to slowly remove the cloud of Freud’s (1899) assumption of infant amnesia and the belief that babies could not remember and did not feel pain. It was assumed that because the neural structures for explicit memory and perception were not fully developed, infants did not experience pain, and, if they did, they wouldn’t remember it. Until the late 1980’s, infants were subjected to surgery without the benefit of anesthesia (Anand & Hickey, 1987; Anand et al., 2007). To be fair, it was also not known at the time how to safely administer anesthesia to newborn babies. Chamberlain’s (1999) research review illuminates the past century of denial in medicine and evidence that prenatals and neonates do remember and certainly feel pain. Merker (2006) and Joseph (2003) highlight the fact that consciousness is possible without a developed neo-cortex.

Now we know that babies have exquisite *implicit* memory and heightened sense of awareness (Schore, 2003). Babies are learning *in utero*, during birth and the early moments, and
months that follow. Our earliest experiences imprint and become our subconscious programming. For example, my client Susan’s grandfather died a few months before her birth. As she experienced her mother’s grief, she decided that she needed to take care of her mother. Which she did; even as a small child, Susan watched her mother carefully and, if there was upset, she would do whatever she could to make it better. She noted how this decision had become a pattern throughout her life of caretaking and denying her own needs.

**Embryology: Earliest Psychological Imprints**

During the first three months of intrauterine life, the embryo is particularly vulnerable to both physical and psychological conditions. At this early time, the neural systems are mainly undifferentiated and very dependent on a safe, and welcoming environment (Anisman et al., 1998; Cicchetti & Tucker, 1994; Cicchetti & Toth, 2009). Brain tissue is growing and differentiating very rapidly during this critical period and is particularly susceptible to its environment (Cicchetti & Tucker, 1994; de Kloet et al., 1996). High levels of maternal stress can change and retard brain development due to elevated levels of maternal stress hormones (Glynn et al., 2000).

**Being Wanted, Unwanted or Abortion Ideation**

Research and clinical experience reveal that whether or not a child is wanted makes a huge difference in the child’s early and long-lasting psychological imprints and may also have physiological affects. Clinical case studies as well as research with prisoners has revealed that an experience of the fetus of being unwanted, or the parents considering or attempting abortion, has some long-term psychological influences, as well as potential changes in brain structure and function, thus creating additional vulnerabilities to future stress for neural networks (Sonne, 1997).

An unwanted pregnancy creates stress for both mother and fetus. The stress of a couple’s ambivalence toward their unborn child can yield negative consequences for later development. An unresolved, unwanted pregnancy can seemingly make the child more vulnerable to schizophrenia, and can be a marker for behaviors associated with risk in either the mother, or the child (Myhrman, et al, 1996). Scandinavian researchers have also found that the stress of an...
unwanted pregnancy may interfere with fetal development and may result in a higher incidence of malformations (Bloomberg, 1980).

**Case Vignette**

‘Sharon’ often seemed both insecure and oppositional: she was, metaphorically and literally, afraid she was going to be annihilated at any time. Through her studies, she began to investigate her earliest experiences where she connected her anger at the world and the fact that she had been her mother’s failed abortion. Her anger was a deep defense against her belief that she was bad, that she hurt people by simply being in their presence, and that she didn’t belong anywhere. In order to survive, she believed she had to be confrontational and seize anything she got. She had difficulty maintaining friends or close relationships. She attended an intensive 10-day healing retreat where, for the first time, she had an experience of feeling safe in her body, and within a caring relationship with the therapist, and so could differentiate her mother’s experience of being unprepared for a child, and see that this was not about her. She also experienced herself as a good and worthwhile person.

**Gestation**

Events during gestation continue to have both physiological and psychological effects on the growing fetus, for good or ill. Numerous studies consistently support: “... [the] ‘fetal origins hypothesis’ that prenatal environmental exposures – including maternal psychological state-based alterations in utero physiology – can have sustained effects across the lifespan” (Kinsella & Monk, 2009, p. 425). Our concern here is not so much with the physiological outcomes, but the psychological factors that mediate for health and resiliency, or less-than-optimal outcomes. Talge et al., (2007) review a number of studies that showed that children of stressed mothers are at higher risk for cognitive or emotional problems including general anxiety, Attentional Deficit Hyperactivity Disorder (ADHD), and possible language delays. Prenatal conditions, especially maternal dysregulation that accompanies anxiety and/or depression, also play an important role in the formation of the infant’s self-regulatory systems (Thomson, 2007). The ensuing hyper-reactivity of the fetal defensive reflexes tends to predispose the infant towards a behaviorally defensive stance, resulting in a predisposition toward aggression and survival, instead of creativity and relationship (Davis & Sandman, 2010; Degangi et al., 2000; Fishbane, 2007;
Thomson, 2007). Thus, these less than optimal beginnings can leave the infant vulnerable to the possibility of mental distress or illness (Kinsella & Monk, 2009).

The mother’s psychological and physical state also greatly impacts on the quality of the attachment that forms between the mother and baby. Much has been written about the importance of post-natal attachment. Prenatal and perinatal psychology and the sciences of epigenetics, neuroscience and Porges’ polyvagal theory all emphasize that the attachment structures are laid in place, even before birth. In fact, the entire prenatal period lays the groundwork for attachment, giving credence to the importance of supporting, not only pregnant mothers’ physical health, but her psychological health, as well (Doan & Zimerman, 2003; Mulder et al., 2002; Porges, 2011; Salm et al., 2004; Sandman et al., 2011; Schore, 2002).

The earliest pioneers in prenatal and perinatal psychology have firmly established that infants are: quite perceptive long before birth; are aware of, and sensitive to, the mother’s thoughts and feelings, as well as changes in their environment (Chamberlain, 1988; Cheek, 1975; Vemy, 1981). For this reason, we encourage expectant parents to speak directly to their prenate, sing, and even read to them, on a regular basis. It is also important that parents protect their developing baby from potentially stressful circumstances, such as loud noises, angry outbursts, any form of domestic violence, or other noxious stimuli (McCarty & Glenn, 2008). Providing such protection and inclusion gives a feeling of safety and belonging, and lays a strong foundation for all attachment relationships.

Case Vignette
Ryan came to me because, although he liked his job, he was ready to quit because of the stress he routinely experienced. He reported that his co-workers got into loud, but mostly friendly, arguments and, when he heard their raised voices, he became quite anxious. He wasn’t able to concentrate, and found himself “spacing out”. As we explored his history, he became aware that from the time he could remember, he over-reacted to any conflict, and if criticism was directed toward him, he shut down and completely “disappeared”, as he called it. He reported that his home when growing-up was “normal”, with no unusually harsh treatment, and that his parents rarely argued or fought. We were puzzled about his intense reaction to conflict, so he asked his father about it. His father explained that before he was born, they were under a lot of stress, and he and his mother fought bitterly, almost daily. At one point, they spoke with their minister, who recommended a couples’ workshop and therapy, where they learned to communicate better, were
able to remove some of the stressors, and got the support they needed to become new parents. When he was born, they took a vow that they would never fight in front of him, and had mostly been able to work out their differences amicably.

We worked with the fear he experienced in utero, how helpless he felt, and the mental model he had created about himself and the world from that state. He realized that some part of him believed that, “Something must be wrong with me; the world is not safe; and I have to guard against causing trouble or something really bad will happen.” As he differentiated “then” from “now”, and experienced the sensation of safety in his body, he was able to create a new mental model of himself: as a deserving and capable person; that he could appropriately discern safety and threat; and that most of the time the behavior of others around him (especially at work) had nothing to do with him. Within the safety of the therapeutic relationship, he gradually found his voice, and experienced himself as a vital part of his work team, even when they were jousting and teasing each other.

Birth

Of all the events of our lives, birth is our most important transition, for good or ill. The experience of that journey creates a physiological and emotional imprint and sets a pattern for future transitions, as well as establishing a mental model of ourselves and the world. Childbirth often creates more stress, both emotional and physical, than many later incidents in infancy, with the exception of abuse and severe neglect. There is persuasive evidence, from many fields, that birth is often the most traumatic event of our lives and creates profound psychological and spiritual imprints that are etched in our implicit memory and “profoundly affects our psychological development” (Grof, 2006, p. 131). If we emerge from a safe and nurturing environment; if our passage into the world is unhampered and within our own timing; and if our connection with the mother is unbroken; we are most likely to experience and believe the world is a safe place. Conversely, if our experience has not felt safe and connected, if the process itself is traumatic, and/or we have had long (enforced) separations from mother, we are quite likely to create a mental model that “there’s something wrong with me and the world is not a safe place”.

A number of therapies have evolved to work specifically with birth trauma, each having its own nomenclature and protocols (Castellino, 2000; Chamberlain, 1988; Emerson, 1989; Glenn, 2002; Grof, 1985). Space does not permit the elucidation any specific model here.
However, included below are some examples of clinical observations from decades of work with clients. Simply incorporating a pre- and perinatal lens into any Body Psychotherapy practice can be quite beneficial. Following are some considerations:

**Clinical Assessment and Birth Imprints**

Although it may not be obvious, as humans, we seem to always be pushing ourselves toward healing or wholeness. As both children and adults, we want to be seen and heard, we want to have someone to help us hold our pain, and to help us make sense of our experience. To that end, consciously or unconsciously, we give clues to our experience; we act out what has happened to us; we react from our feelings; and indicate especially anything that is “unfinished” or incomplete. This helps provide significant markers for the possibility for healing.

In addition to a usual assessment, if we hold up the pre- and perinatal ‘lens’ as we listen to the client’s language and their non-verbal cues, this can help us unearth their earliest trauma and subsequent mental models or core beliefs. There are often tips about their early experience that the client is not consciously aware of. We know that every birth is different, and that each reaction depends on a myriad of factors. While we can never say that a particular birth experience yields a specific outcome, we tend to see a range of patterns that merit consideration. The following are some examples for guidance:

**Cesarean Section Case Example:**

I worked with 16-year old, ‘Tina’, who was a patient in our residential treatment facility for repeated episodes of cutting (self-harm) on her forearms. In a family session, I asked her parents, with Tina’s permission, to describe her birth. As her mom explained the planned C- section, where she was to be fully awake and dad was at her shoulder, Tina curled up on the couch between her parents in a fetal position. When mom described how they had cut her belly, Tina began to cry, and a tiny girl’s angry voice emerged, “Yeah, then they handed me to daddy and you disappeared forever!” Mom had had medical complications, and wasn’t able to see her daughter for over 24 hours, and only intermittently for the first week. As we worked with this early experience of abandonment, Tina was able to see that her self-cutting was a cry for help: she wanted someone to see how terrifying was her on-going fear of abandonment.
An Aside for Further Research:
During my two years as clinical director of an in-patient treatment center for disturbed teenagers in the mountains of Southern California, we took extensive family histories of these young people, including such questions as: ‘Was this a wanted child?’ ‘What was your relationship and your life like during the pregnancy and birth of your child?’ ‘What stresses did you experience during pregnancy?’ ‘Was there domestic violence, drug abuse or traumatic events pre- or post-birth?’ ‘What was the birth process like?’ ‘Was the baby allowed to stay with you, or was there separation?’

Much to our surprise, we discovered that every teen, yes 100 percent, had experienced some type of trauma between conception and their first birthday. Incidents included events such as: Being unwanted throughout the pregnancy; a failed abortion attempt; a very stressful pregnancy; death of a close family member; being placed for adoption; prolonged separation from mother; traumatic C-section or other birth trauma; time in the Neonatal Intensive Care Unit; surgery at a few weeks or months of age; or abandonment of the family by one parent.

The most gratifying part was that as we worked with the family, with these early traumas that often led to current issues, many of the teens were able to go home and lead productive lives. It seems that during adolescence, being a time of huge transition, many teens amplify or reenact their first transition into the world, and when that pattern and it’s ensuing mental models are identified, worked with – as they are held in the body and evidenced behaviorally – teens are able to move forward with more self-confidence, connection and creativity.

C-section:
Adults or children delivered by caesarian section often have difficulty taking initiative: “I usually wait for someone to come and pull me out.” “I have trouble knowing when to begin things.” Children delivered by C-Section, when playing in a tunnel, will most always “pop up” in the middle. It is interesting to note that planned or medically induced C-Section, and emergency C-sections, usually create different dynamics. In planned sections, the baby often feels defeated before they begin: their capacity for initiating, and their impetus for movement, is often stymied. They might say things like: “I tend to rely on other people.” “I can’t do it by myself.” There is usually a sudden fear that surrounds an emergency C-section: things move very fast, and either the mother or baby or both are in danger. Some beliefs might include: “I’m a failure”; “I can’t get it right;” “This must be my fault”.

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Umbilical Cord Trauma:
Having the umbilical cord around the neck may have been a frightening experience. This is sometimes the reason the baby cannot descend into the birth canal. My client, Tom, had an aversion to tight collars, and couldn’t stand anything around his neck. He even shouted at his wife, in a particularly difficult couple’s therapy session where she wanted them to buy a house now, “Gee, Jill, you’ve really put my neck in a noose!” With that clue, we were later able to explore his birth experience, where he felt powerless to take the next step that was required.

Another client, Hanna, who was born breech and had cord trauma, always wore something around her neck—a scarf or other tie. It was like her security blanket and if she was without it, she began to get anxious: a by-product of her therapy, in addition to increasing her confidence and decreasing anxiety, was that she began to release her need for the scarves.

Forceps or Vacuum Extraction Delivery:
The use of a strange looking pair of clamps that is placed on either side of the baby’s head has dwindled as vacuum extraction has become easier to use. Clients, who have been delivered with the use of forceps, often resist authority or being told what to do. Some phrases might be: “I don’t feel I have a choice”; “I’m always pushing against (or afraid of) authority.” Some phrases expressed by those whose birth included vacuum extraction might be: “I need to be rescued”; “People hurt you”; “My body is not my own.”

Anesthesia:
Common until a few decades ago, general anesthesia is rarely used in birth today. The baby also received the anesthesia, and it could be a frightening experience, a feeling of being out of control and a giving up or dying. As teens or young adults, they might resort to drugs. Examples of common phrases include: “When it’s time for me to take action (or try something new) my energy drains and I’m no longer enthusiastic but just kind of give up on the idea”; “I often feel numb”.

Induction:
If labor does not progress properly, or if a baby is overdue, drugs are often used to induce or speed up labor. Depending on the amount used, it can be a frightening experience for the baby. Some of the language might include: “I’m a failure. I don’t do things right”; “I can’t do things my own way (or within my own timing)”; “I always feel rushed”; “What I want (need) doesn’t matter.” Seven-year old Myrna was often angry at her mother as she felt rushed by her: she also
took undue physical risks. Her birth had been induced by prolonged doses of Pitocin. During a play therapy session, Myrna blurted out, “I don’t know where I’m going, but I have to hurry, hurry, hurry.”

**Beginning to Work With Patterns**

Even more than phrases expressed by the client, we notice life patterns presented in metaphors and stories that echo possible birth experiences. Repeated behaviors that create anxiety, lethargy, helplessness, numbing or addictions can also have prenatal origins. One important tool, we call “Linking”, is used to discover and work with early imprints, illuminates the emotional connection between the client’s present difficulties and unresolved prenatal and perinatal events. With this tool, we help the client link a current experience with past trauma and unconscious beliefs or mental model. For example, when the client speaks about a current issue, such as, “I’m really afraid my partner will leave me,” we gently guide them to the physical sensation of that experience. After they describe what they notice, we gently ask, “Is this feeling familiar?” Most often, the client will say, “Yes”, to which we respond, “Can you imagine an earlier time, maybe as a young adult, when that familiar feeling was present? The situation may be very different, but the familiar feeling is there”.

When we’ve explored that scenario, focusing on the sensation, we ask the client again if they might allow their mind to wander back to an even earlier situation, where this familiar feeling was present and investigate that childhood experience. Then, we ask them to invite the very earliest scenario they can imagine when their ‘Little One’ might have experienced this sensation. This is often between three and six years of age. While this is not a birth scenario, it is almost always (somehow) a recapitulation or mirror of that earliest experience. The client then tries to see, sense, or imagine herself as a ‘Little One’, discern what she might have felt at that time (frightened, alone, powerless, etc.), then what she might have been telling herself about herself (something must be wrong with me).

Next, we examine what she might believe about others and/or the world (“They’re okay but I’m not; I’m not safe”). Finally, we discern how she decided to be in order to get her needs met (“I’ll be good; take care of a parent; be demanding”). This process helps the client discern their mental model. Having an experience, in relationship with the therapist, from the adult state, the client is now ready to determine the real Truth about their ‘Little One’: (“I am good; I


deserve love; I can do this, etc.”) As you work with this over time, it will be easier to help the client move back into more implicit memories, especially around birth and before.

Frequently, the prenatal or birth experience that created the mental model will appear in a body movement, such as head in hands, slumping over, or curling up, pushing away, feeling numb, or frozen, etc. The voice sometimes sounds very quiet and the language is quite young: “They put me in a basket and mommy go far, far away”; “Get away. I do it”; “Does my mommy love me?”

Although facts can be interesting and helpful, it is important to note that it is not the discovery of the story that is the key in working with prenatal and birth imprints. It is going into the experience, with a caring witness, being curious about what will arise, allowing emotions to emerge naturally, while remaining connected in the present moment and staying with the experience until it shifts. Then, peering inside the experience with the client to note what it was like for the ‘Little One’, what he or she might have (unconsciously) believed about her/himself, the world and in some way deciding how to be in the world to get her/his needs met. This is connected to the adult experience and the life-long patterns of relating.

Healing Prenatal and Birth Imprints

It is beyond the scope of this chapter to give full consideration to the principles for integrating prenatal and perinatal psychology into Body Psychotherapy practice. For more specific information, see ‘Essential Principles for Prenatal and Perinatal Psychology Practitioners’ (Glenn & Cappon, 2013).

Summary

Research from disparate fields over the past several decades offers increasing evidence that experiences from pre-conception through the first year of life lay the foundation for physical and emotional development, including brain development and mental health or mental illness. We now understand that the foundations for self-regulation, relationship and resiliency begin even before conception. In Body Psychotherapy we know that the body records experiences and must be included in the healing process. Prenatal and perinatal psychology adds the importance of our earliest development to this understanding and provides a significant foundation for our practice of Body Psychotherapy.
References


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