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The Prenatal Period as the Origin of Character Structures

Marc Costa Seguí

Barcelona, Spain

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Abstract: The present study is based on the prenatal material of 14 psychotherapy patients in Psycho-corporal Integration during an uninterrupted period od 5 to 11 years. In this work we have only been able to briefly explain a few of these cases. The rest have served to support the hypotheses of this work. This type of psychotherapy allows one to acheive, in time, spontaneous psychotherapeutic regressions that facilitate concrete intrauterine experiences. Their very number and variety allow the deduction that the embryo and the fetus may experience *in utero* difficulties which we have classified as schizoid, oral, symbiotic, psycopathic, masochistic, phallic, and hysteric, thus establishing the possible intrauterine origin of character structures and, therefore, the somato-psychic core of conflicts.

Zusammenfassung: *Die pränatale Lebensphase als Wurzel der Charakterstrukturen.* Die vorliegende Studie gründet auf dem vorgeburtlichen Ergebnismaterial von 14 psychotherapeutischen Patienten, die mit der Methode der „psycho-korporalen Integration" über Zeiträume von 5 bis 11 Jahren behandelt wurden. Wir können in dieser Arbeit nur einige dieser Fälle vorstellen. Unsere übrigen Befunde dienen als Unterstützung für die Hypothesen in dieser Arbeit. Dieser Typ von Psychotherapie erlaubt es spontane zeitliche Regressionen zu erreichen, die konkrete intrauterine Erfahrungen zugänglich machen. Die große Zahl und die unterschiedliche Charakteristik dieser Erfahrungen erlauben die Ableitung, daß der Embryo und der Fötus im Uterus Schwierigkeiten erleben können, die man entsprechend den klassischen Neurosestrukturen als schizoid, oral, symbiotisch, psychopathisch, masochistisch, phallisch und hysterisch klassifizieren kann. Diese Klassifizierungen beschreiben den möglichen intrauterinen Ursprung von Charakterstrukturen und stellen deshalb den somatopsychischen Kern von Konflikten dar.

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The initial theorization of the character by S. Freud and its posterior development by W. Reich and other authors will be resumed. A precise ordination of character structures (or evolutive constructs of individual differences) will be established on the basis of these studies and the clinical material of those psychotherapy patients in Psycho-corporal Integration who not only relive their early childhood but

Correspondence to: Marc Costa Seguí, clinical psychologist and psychotherapist in Psycho-corporal Integration, Sant Elíes, 31-33, esc. B, 4t 3ª, 08006 Barcelona, Spain

even the intrauterine period. In this field, experiences become increasingly more *somato-psychic*, that is to say, they are experiences which involve the body directly and which make the psyche register and process events in a very emotional and rudimentary manner. It will be shown that this clinical material coincides with the most important biological processes of the embryo and fetus, whose evolution may come into conflict with the intrauterine ecosystem, the veritable resonance box of the psycho-emotional processes of the mother. This conflict-bearing dialogue leads to a profound and unconscious register, the transcendence of which lays in the fact that a great part of intrauterine difficulties enclose the problem of survival. It will be exposed, summarizing, that the unborn already has a somato-psychic registering system, a genetically programmed conduct system, and that it goes through learning processes which generate the prenatal matrices of character structures.

Theory of the Character

Sigmund Freud

Freud laid the foundations for a theorization of the character of dynamic and profound orientation. Even today, his evolutive constructs of individual differences serve as a reference for present-day developments. From the stages of pregenital psychosexual development arise the corresponding character styles: the *oral*, passive and receptive; the *anal*, orderly, obstinate and stingy; the *urethral*, competitive and insecure, and the *phallic*, invasive and seductive. All these traits can be analyzed in terms of particular fixation mechanisms that the person uses to remain anchored to the corresponding stages of early childhood[1].

The character structures close their cycle between the age of five and six[2], when the latency period begins, during which both sexes repress their paternal oedipal attractions[3]. Freud set forth that the character was already established in its fundamental phases during the latency stage and adolescence. Therefore, we must always go back to early childhood to understand the framework of the character[4].

W. Reich and the contemporary theoreticians of the character share this Freudian approach, to which this work also adheres. But with one added hypothesis: the vicissitudes that the embryo and the fetus experience during gestation and birth can determine the somato-psychic origin of the character structures.

Wilhelm Reich

Reich's work as Director of the Technical Seminar of Vienna for psychoanalytical therapy, which he developed from 1924 on, lead him to conceive his work *Character Analysis*[5]. In it he expounded six definite characterological structures, based on the study and analysis of individual resistances[6]. We will not explain them here, due to the brevity of this work. But we will summarize a couple of fundamental concepts (muscular armor and the principle of functional unity) and his theory of psychoemotional conflict.

In 1934 Reich introduced an important construct for the future development of psychotherapy: *muscular armor*. This is the somatic correlate that psychic conflicts are anchored to: it is the corporal form (blocked postures, skeletal-muscular ten-

sions) with which characterological resistances manifest themselves. For Reich, psychic and somatic phenomena are indistinct, dialectic aspects of the same whole. From that arose his *principle of functional unity* between psyche and soma: the psychological and the corporal condition each other vegetatively and function at the same time as a unitary system. With it is established the importance of intervening also in the body within the psychotherapeutic process, both in the vegetative aspect (especially through breathing) and the skeletal-muscular structure (through diverse direct manipulations). And so originates a new type of work in psychotherapy, characterized by the inclusion of the body with the same rank as the mind. Psycho-corporal Integration, created by the author of this document, looks to this historical precedent as its source of inspiration.

Reich was very explicit in his theory of psychoemotional conflict: "Characterological armor is developed as the chronic result of the conflicts between instinctive demands and the frustrating external world"[7]. These instinctive demands are the ultimate depth, the primary layer: a spontaneous, sincere and simple world. Reich fervently defended the ultimate goodness of human nature, contrary to Freud's final position regarding instincts. Precisely in his essay on *masochistic character*, Reich tried to provide a clinical refutation of the "Thanatos", or the Freudian death instinct[8]. Human malaise was not in any way due to a biological urge towards disintegration or displeasure, but to the permanent, lacerating and insidious effects of social and, therefore, family conditions that were frustrating and destructive.

Reich assumed the inalienable responsibility of society in the genesis of human psychopathology. In this work, that responsibility is set forth beyond birth, in the intrauterine period. The hypothesis is that the experiences of the mother and of the medium she is situated in decisively condition the character of the being in gestation inside of her. Instead of innate destructive drives, our intrauterine clinical histories explain reactions of extreme fear and/or aggressiveness to protect survival. The extreme pain that some people have experienced in the prenatal period can to a great extent clarify the importance of malaise and of destructive behaviors in these people.

We also postulate, in short, a fundamentally good human nature, in which the human being (the embryo, the fetus, the newborn, the adult) knows deep down what he or she needs. That is our approach in the therapeutic process of Psycho-corporal Integration, that tries to facilitate the gradual emergence of the person's unconscious and archaic experiences and drives. The only thing people really needs to be able to manifest it is the establishing of a solid bond of confidence and a margin of affective and comprehensive contact .We have the clinically proven certainty that once these primary processes manage to drain their negative biographical charges, a positive and healthy life drive always appears.

Reich's Continuators

Among the theoreticians of character that have followed Reich's footsteps, one might mention A. Lowen[9,10], R. Hilton[11], S.M. Johnson[12,13] and R. Kurtz[14], who have gone on to establish an increasingly more precise ordination of character structures in terms of the evolutive and infantile process. In Psycho-corporal Integration, we have adapted the classification made by Ron Kurtz, to which we add

a structure (or substructure) that we call Symbiotic. The need to add this new structure appeared along with the clinical experience of various patients, whose characteristics didn't exactly correspond to classification, and with the theoretical inspiration of the writings of J. Masterson[15] and S.M. Johnson[16].

Next, let's see a comparative chart of classifications according to diverse authors:

S. Freud	A. Lowen	S.M. Johnson	R. Kurtz	M. Costa[17]
Oral	Schizoid	Schizoid	Schizoid	Schizoid
Anal	Oral	Oral	Oral	Oral → ORAL
Urethral	Psychopathic	Symbiotic	Psychopathic I	Symbiotic
Phallic	Masochistic	Narcissistic	Psychopathic II	Psychopathic I
	Rigid	Masochistic	Masochistic	Psychopathic II → ANAL
		Rigid	Phallic	Masochistic
			Hysteric	Phallic → PHALLIC
				Hysteric

We must remember that these classifications basically refer to defensive attitudes structured in the form of character, and that each individual generally presents a mixture of all the structures, with one basic structure and other secondary ones. It is the so-called "*Character Histogram*", that attempts to measure, in approximate percentages, the proportional amount of each structure that corresponds to each individual.

The Psychotherapeutic Process in Psycho-Corporal Integration

The Principle of Psychosomatic Synchrony and Final Work with Defenses

Psycho-corporal Integration is a psychotherapeutic synthesis system created by the author of this work during seventeen years of complete professional dedication to individual and group psychotherapy. The central axis of the system has always been the search for a profound and synchronized work with psychic and somatic instances. From this arises the *principle of psychosomatic synchrony*, that proposes the progressive attainment of globalizing experiences between the mental-cognitive, the instinctive-emotional, the physiological-vegetative and the skeletal-muscular. With it is propitiated a peculiar final work with the defenses, directed towards achieving first, the *synchronic defense experience* (SDE), as a means of experiencing and becoming conscious of the painful experiences consigned to the unconscious, and second, the *synchronic defense opening* (SDO), as a means of regaining natural organismic reactions in order to face pain and transform it.

Factors that Facilitate the Psychotherapeutic "Experience"

In Psycho-corporal Integration, we attempt to progressively reach the attainment of authentic *experiences* in the phenomenological sense of the term. An "experience" must be able to be *felt* (sensation-perception), must contain *awareness and meaning*, and must reach *expression*. It is precisely in emotional expression where

the processes of discharge and energetic recycling are carried out, which allow one to cyclically achieve increasingly elevated energetic charges and increasingly deeper and more regressive therapeutic processes.

In Psycho-corporal Integration, we work with diverse experience-facilitating factors. The first, and most decisive, is the importance given to the psychotherapeutic bond, through attending to and elaborating communication and contact between therapist and patient. In second place there are aspects that can be summed up in three theoretic-methodological principles: the *principle of spontaneous psychosomatic expression*, which allows the patient to manifest him or herself in an absolutely free manner; the *principle of centering on the patient*, which propitiates attention and a constant attempt at comprehension on behalf of the psychotherapist, and the *principle of psychosomatic non-violence*, which forces the therapist to respect the material, the meanings, the processes that the patient him or herself goes on to discover, avoiding interpretation in order that the patient him or herself creates the space and possibility of finding his or her own solution. Thus, an atmosphere is created that facilitates confidence in the therapeutic relationship, and in addition, the self-affirmation of the patient is made possible.

Psychotherapeutic Regressions

All the above stated allows for, in a more or less advanced moment of the process, therapeutic regressions to arise, without forcing, in prenatal and perinatal strata. It appears as if the person, upon remembering emotional and expressive contact and functioning, had progressive access to his or her childhood and, finally, intrauterine life. It's as if the fact of synchronizing mind, body and emotions were the entrance door for recovering archaic, biographic and pre-biographic experiences. In fact, this is how the child functions, contrary to the adult, whose psychosomatic capacities are already specialized and divided.

In short, upon entering prenatal and perinatal processes, the patient finds him or herself in a *synchronic experience* that guarantees the consistency of his or her experiences. The patient feels them to be real or almost real and often the data from these experiences has been verified with historical reality.

This data confirms, once again, that the prenatal being possesses a good registering system. On this topic, our hypothesis is radical: all prenatal and perinatal events, from conception to delivery are registered at deep unconscious levels. Practically, this is what the prenatal and perinatal regressions of patients of Psychocorporal Integration lead us to assume. Theoretically, we support this hypothesis with the approaches of K. Pribram regarding holographic memory[18].

The Survival Drive and the Somato-Psychic Experience

We understand the *survival drive* to be all those internal or external actions or reactions that produce a living being during moments in which, in one way or another, the continuation of his or her life is in danger. Our clinical experience is that many frustrating or aggressive actions inhibited by the prenatal creature trigger this drive. We consider it to be a *somato-psychic experience* (and not psychosomatic) because the body and its energetic and reflex processes direct the action, while the psyche computes the data in a primary manner.

We can consider intrauterine experiences to be principally somatic. The body of the prenatal being is in contact with the mother's organism and it is through her that it receives most of the external information. In addition, the extreme vulnerability of an organism in maturative growth makes it especially sensitive to any negative stimulus that reaches it through the body.

The Language of Somato-Psychic Signals

Upon carefully observing the manifestations of psychotherapeutic regressions, one can make out what we call *somato-psychic signals*. We understand a signal to be something that occurs enough times and in the same way that it begins to have a meaning. One would say that strong drives generate the necessary conducts for life and intrauterine development. In this way, a particular somato-psychic language appears, that usually manifests itself in two different stages.

The first of these stages tends to deal with painful or traumatic experiences. They are the signals of the language of pain that can be found in diverse parts of the body according to the nature of the frustration or aggression received. In some cases, the energetic sensations of malaise and corporal pain tend to last various days. These are contractive corporal experiences, very deep tissue blocking. We call these types of experiences *synchronic defense experience*, as before-mentioned.

The second stage begins when pain begins to open up and uncontrolled, apparently unorganized and worthless corporal reactions appear. It is the body's attempt to recover a complex string of reflexes that was disarticulated by the frustrating and/or aggressive responses of the medium. And generally the process passes through the strong and consistent experience of negative emotions, that we interpret as a healthy organismic reaction to external attacks. This reaction was inhibited in its day and must be able to be expressed now in order to recover the truncated, natural *in uterus* drives. It is a question of opening corporal movements, progressively vigorous, intense and full of energy, habitually tinged with a strong dose of anger. With this we arrive at *synchronic defense opening*, mentioned above. With it, we have the exclusive way to recover the natural, innate conduct system.

Let's just say, in short, that we possess this natural system, with its own language and code, starting at conception. As it is obstructed within the intrauterine medium, it generates primary defensive conducts with another language and another code: the language of malaise and the code of confusion. Consequently, we consider that many psychopathologies – and also positive traits – find their origin in the prenatal period of life.

Undoing this negative intrauterine bond means restructuring the archaic relationship with the mother. This task is done through the transferential relationship with the psychotherapist and through symbolic work with the origins of the maternal prenatal relationship. In Psycho-corporal Integration, it is considered that not repairing these origins always leaves negative traces that never disappear, especially on a somatic and energetic level.

Birth experiences are also considered important in the formation of character foundations. Although having a relative duration in time, the intensity of their events allow for a possible learning through "imprinting", just as David Cheek pointed out in 1975[19]. In this work we'll limit ourselves to prenatal experiences

and leave perinatal material for another work. We'll simply indicate that in the relatively brief temporal space of childbirth work, a consistent rereading is done of all situations that shape each of the character structures. At least that is our hypothesis.

Prenatal Experiences in Psycho-Corporal Integration

The Schizoid Experiences

Embryological Data

With the fertilization of the ovule by the spermatozoid and the fusion of the pronuclei, appears the zygote, the first cell capable of becoming a human being. The zygote advances towards the uterus through the Fallopian tube during 4–5 days. Along the way, the zygote increases in size, although it divides itself into increasing smaller cells, until becoming a free blastocyst. Between seven and nine days after fertilization, the stage of implantation in the uterus is produced, extremely important for the evolution of the germ.

We include all these processes in the *intrauterine schizoid phase*, characterized by the precariousness of survival. It is know that up to fifty percent (50%) of these cases are lost at the beginning of pregnancy, within the two or three weeks following fertilization[20]. It is assumed, then, that biologically there is an important struggle for survival.

When the ovule is fertilized, the yellow body produces lutien or progesterone, a hormone that protects not only the oocyte, but that hematically originates changes in the endometrium and prepares it to receive the blastocyst. The hypothesis is that, on an unconscious psychoemotional level, the woman who is not prepared for pregnancy can obstruct these processes, to the point of creating serious difficulties for the survival of the new being. If this new life doesn't perish, these obstacles are registered on a cellular level and are ratified with a fixation of this experience of rejection during a large part of pregnancy and life itself.

Clinical Data

Patient "C" presented, from the start of psychotherapy, a central conflict, among others of lesser recurrence: an entire series of persecution experiences in which she felt her life was in danger in a phantasmical way. She started to become aware of the unreality of these fantasies and could relate them to childhood biographical situations; but she couldn't avoid the strong anxiety that was sometimes awakened in her, especially after having lived an episode of aggression, rejection, or loneliness. She was assaulted by images and ideas that she was being followed, attacked and even killed.

At the end of her fourth year of the Psycho-corporal Integration process, this patient began to relive *synchronic experiences* in which she felt herself to be "in an immense space", in which she was jerked around, with a feeling of absolute hostility from the medium. She perceived herself as a luminous ball that traveled through this space in constant danger of disintegrating.

This type of experience repeated itself many times with the sensation that this tiny living mass had to shrink and fold up even to the deepest nucleus of its being

and stay there completely closed. It was the *synchronic defense experience* (SDE), that was generating an abstract, unlimited fear, felt in her very bones, in her joints, in her cranium, in her eyes; it was the fear of losing herself through disintegration or atomization. The way out of this limit situation between life and death consisted in the gradual expression of indiscriminate anger, that went beyond any specific person. She herself used to say that she directed it towards the entire world. She also said that when she came into this world, she hadn't been welcomed; that she had been hated. And only a response of equally destructive proportions could compensate her. But upon expressing her anger, she felt like she was breaking and being dismembered. Her movements were erratic and asymmetrical. Often an iron-like tension arose in the occipital zone, in the articulation of the cranium and the atlas, that restrained movement. Contact with the therapist produced even more anger and accentuated her desires to destroy; but only the maintaining of this contact in a consistent manner allowed for processing all that emotional charge.

Thus was achieved the *synchronic defense opening*, the development of which lead to a new kind of experience. She began to feel that an irresistible force wanted to expel her from the intrauterine space. If she remained in the closed position of protection, she didn't have the strength to confront the situation. This gave way to the need to open her body in an external arch (in frontal convexity), strongly tensing herself on the curvature of her back. This position gave her security and consistency that allowed her to endure the expelling forces, challenging them through an invasive and penetrating body position. This is the *phallic and hysteric experience*, which we shall describe in more detail in the corresponding section.

Patient "C" clearly felt that thanks to this last experience, she could save, although precariously, her intrauterine life. Only the gradual strengthening of a unbreakable bond with the therapist allowed her to go beyond her destructive urges and feel a full right to exist.

The Oral Experience

Embryological Data

Ten to twelve days after fertilization, the egg has been completely implanted and the amniotic cavity has grown larger. From day thirteen to fifteen, the vitelline sac is formed and the embryo consists of a bidermal embryonic disk (ectoblast and endoblast). Between days sixteen and twenty-one, the first morphologic sign of bilateral symmetry appears. The embryo is now tridermal: between the ectoblast and the endoblast is formed intraembryonic mesoblast. Meanwhile, the embryo progressively separates from the trophoblast and the first rudiments of the umbilical cord and the placenta are formed.

From fifteen to twenty days onwards, nutrition by osmosis can no longer be endured, and the first blood vessels appear outside the embryo[21]. The ones that are formed in the zone that lines the internal face of the trophoblast, in the caudal part of the embryo, are important. They are very numerous, they enter the placenta and, therefore, are in contact with the mother. This way the nutrition mechanism is assured for the new being who's trying to survive.

From day twenty on, the primitive segments, or somites, appear, and the folding of the embryo in the cephalo-caudal direction begins, thus taking on the form of a closed "C". This can be interpreted as a position of protection of the frontal part, which is always more vulnerable, with the aim of preserving the maturation and growth of organs and internal systems. The hypothesis is that this closed, protective posture will tend to be conserved in subjects that have suffered difficulties in intrauterine medium.

From day twenty-six to fifty-six, the organogenetic period takes place, and thus appear the main body characteristics. The embryo measures thirty-one millimeters and weighs 2.5 grams, and possesses ninety percent (90%) of the more than four thousand five hundred (4500) structures the adult has. The cephalo-cuadal folding diminishes. It's like a complete miniature human being. The *intrauterine oral phase* ends here.

Finally, we emphasize the somewhat slow development of the lymphatic system and the ganglions, which must be the cause of a well-known fact: embryos don't acquire immunological activity until approximately sixty (60) days[22]. It is the mother who must protect them during this stage. She carries out the complete functions of nutrition, sustenance and protection. The hypothesis is that if on an unconscious psychoemotional level, the mother isn't ready to carry out these functions, the new being registers experiences of privation, abandonment and lack of protection that threaten survival itself.

Clinical Data

Already from the beginning of her process, patient "S" complained of apathy, lack of motivation and melancholy. This state had accompanied her to one extent or another from adolescence. It was a depressive pattern that sometimes prevented her from carrying out everyday activities.

She was able to relate her state of mind with a series of biographical situationes dealing with affection and abandonment. She understood her dependence and susceptibility to separation and to any type of loss. She even recovered her energy and corporal vitality through after allowing herself the anger that produced in her the most varied situations of privation or distance. But she couldn't stop herself from feeling depressed when any of the important persons in her life (her mother, her partner) ignored her or didn't support her.

Around the middle of her fifth year of Psycho-corporal Integration process, she began to enter intrauterine regressions that were explicitly recognized by her. The experience consisted of feeling like a shapeless mass, strengthless, abandoned to her destiny: nobody looked after her. She perceived herself as extremely miniscule and destitute, with a clear feeling of unstructuring and lacking energy. This was the *synchronic defense experience* (SDE), the positive outcome of which was carried out through progressive sustenance contact with the therapist. As the conviction grew that the other person was there and wouldn't abandon her, a strong sensation of hunger arose. As if she had been left without food and she could starve to death. It was the panic at observing the devestating effects of the other person's abandonment, who, upon leaving her without sustenance, was condeming her to disappear.

At this time arose a voracious anger, which lead to a great need to bite and spasmodic movements of her entire body. Thus began the *synchronic defense opening* (SDO), which then awakened feelings of insensibility and hardness around her navel. She said it was "as if the umbilical cord has dried up". The uncontrollable hunger continued, bringing with it a peremtory want of the maternal breast, reliving the enormous deficiency that it had meant for her not to have been breast-fed. The positive soluction of this situation consisted in the psychotherapist giving the patient a feeding bottle when she entered these regressive states. This way the damaged nutrition bond was symbolically repaired.

Later on there arose a series of support and protection needs, which as they were elaborated and were metaphorically satisfied, contributed to reestablishing a gradual sustenance bond with the therapist who guaranteed nutrition in the broadest sense of the word.

The Symbiotic, Psychopathic and Masochistic Experience

Structural and Conduct Data

The psychopathic and masochistic experience takes place in the period that goes from the start of the third month to the end of the fifth month. The symbiotic experience oscillates between the oral and the psychopathic stage.

From day fifty-six (56) on, the organism that is developing in the maternal uterus is given the name of fetus.The curvature of the nape is reduced and it takes on an increasingly more human appearance. At eight (8) weeks, slow, vermiform (worm-like) movements are observed, which occur up and down the extremities and trunk of the fetus[23]. It seems that these are spontananeous movements, possibly produced by endogenous stimuli.

These type of movements are often observed in the intrauterine regressions of Psycho-corporal Integration: they are considered the rudiments of the orgastic reflex postulated by Reich. The hypothesis is that this is the basic natural movement that the fetus uses when it needs a general energetic discharge and which it will fundamentally use during its own birth.

Around day sixty (60) the *neuromuscular stage* of fetal conduct begins. The reflex motor behaviour will follow the same time-spacel sequence as the neuronic maturation: first the facial region, next the trunk, and finally the extremities. At twelve (12) weeks, the stage of suprasegmental integration appears. Thanks to it, the the fetal musculature not only manifests a rest tone but also a postural tone. Between twelve (12) and sixteen (16) weeks, the sucking reflex is outlined, and the fetus swallows with its mouth closed. Between sixteen (16) and twenty (20) weeks, the eyeballs move and the first isolated inspiratory movements appear.

From the beginning of the third month to the end of the fifth, the fetus undergoes a rapid growth in length (five (5) centimeters per month, approximately) and its weight at the end of this period is around five hundred (500) grams.

All this indicates that the fetus is beginning to stand out ostensibly. Its presence becomes evident to the mother, who should acknowledge the existence of a being who is beginning a very rudimentary *behavioral autonomy*, a gradual *subcortical control*, and a progressive need of space. But if the mother can't acknowlege the

other and link herself to the other, she will tend to deny the fetus the space and the autonomy through some kind of unconscious invasion or manipulation.

Clinical Data

During this entire stage that goes from the beginning of the third month to the end of the fifth, four character structures can be distinguished: *symbiotic*, *psychopathic I*, *psychopathic II* and *masochistic*. They all arise from the same conflict with autonomy, space, and control, but with different styles and strategies.

The *symbiotic structure* is found to still be oscilating between the oral structure and the psychopathic structure. As a clinical example we shall take patient "M", who from the very beginning of psychotherapy showed a strong relational conflict. On the one hand, the enormous necessity to be with the other (the partner). On the other hand, a strong urge to separate himself and to be autonomous. When living with his partner, he felt strongly oppressed; but when he separated himself and kept a distance, he was overcome with an unbearable anxiety that forced him to return. One could say that he lived under the motto, "I can't live with you or without you".

Most of the intrauterine experiences that went on to appear after the fifth year of psychotherapy were centered on an experience of genuine terror of having physical contact with the other. He had to avoid contact with the psychotherapist, which he sensed to very painful. He would bend ventrally and make movements retracting the body backwards, especially if the psychotherapist approached him. He could finally have physical contact; but he would soon overwhelmed and have to withdraw. Thanks to this intermittent contact a very intense pain started to emerge in his cranium, that radiated towards his neck and shoulders. Upon working on the tensions that produced this pain, a violent and uncontrollable movement of the head arose: he needed to hit and butt with it.

With these movements appeared an unbearable choking, that was bringing him without fail to his death. He knew that all this was due to the painful contact produced by the enormous pressure exerted by the maternal uterus. Here was the limit of the experience: he decided to accept the pain and fear that was produced in him by any type of contact that involved dependence and, therefore, oppression. He established consistent agreements with his partner to satisfy his need of support and, at the same time, to have substantial spaces of autonomy. And with the psychotherapist he agreed upon a contract that turned out to be highly efficient: to have sessions only when he needed them. He could thus exert his autonomy and have at his disposal an intermittent contact, which was exactly what he needed to feel free and to feel that he had the possibility of choosing for himself. The result was the gradual conclusion of his therapeutic process.

We shall give no example of the *psychopathic II*, *psychopathic II* and *masochistic* structures for reasons of space and time. Let's just say, briefly, that the *psychopath I* has processed his or her need for autonomy from a primary relationship of manipulation and utilization through, hard power; therefore, in his or her intrauterine experiences he or she tends to feel suffocated, forced, and even massacred. The *psychopath II* has been manipulated and humiliated in his or her autonomy in a seductive and falsely affectionate manner; consequently his or her intrauterine experiences are tinted by suffering which means feeling overwhelmed and harassed,

but with the confusion inherent to an apparently kind way of making him or her feel this way. The *masochist* has been invaded, literally crushed in his or her desire for independence. He or she has had to exert a great retentive control, not only to restrain his or her need of freedom, but also to suppress the powerful negative emotions of fear and violence before the humiliation of the other. His or her intrauterine experiences are marked by a titanic endurance before the perception of the crushing to be faced if he or she doesn't take charge of this suffering and the anger of the other.

The Phallic and Hysteric Experience

Structural and Behavioral Data

At the end of the fifth month and during the sixth, the subcortical control definitively evolves. Postural reflexes are quite evident and the fetus does not only react to tactile stimuli, but also to pressures and vibrations. It could be said that is already a perfect *subcortical animal*, capable of the certain postural control and movement that this implies. But also having the possibility of directly processing emotions and of learning. Already in 1948, D.K. Spelt affirmed that the human fetus could be experimentally conditioned in the final months of pregnancy[24]. In short, the last four months of pregnancy are a stage in which the fetus can express tiself and communicate at a considerable level affective communication and awareness.

During this period, the fetus carries out various spontaneous movements. The "storm of movements" described by Saint-Anne Dargasies in 1974 characterizes the fetus of six months[25]. At twenty-eight (28) weeks, the movements are sectorized in the lower extremities. At thirty (30) to thirty-six (36) weeks, movements of partial rotation of the trunk appear, with frequent flexion-extension movements of the four extremties that make the body move. After thirty-six (36) to thirty-seven (37), and due to the increase in weight, especially noticeable in the final two months of gestation (approximately seven hundred (700) grams per month), spontaneous mobility decreases.

This great amount of mobility, the progressive maturation, and the increase in size seem to make the fetus secure enough to finally open up the frontal flexion of the body and to expose its chest, abdomen and genitals, ready to make contact with the medium. It's like opening up the position of anterior periods so that the anterior part of the body is available to open up and move towards the other. During the final two (2) to three (3) weeks, the fetus stops performing this movement due to its size, since it is now preparing for an important event that entails a new cycle of experiences: birth.

We consider this frontal opening to be very important for the fetus: it has finally constructed the pregenital orgastic reflex movement, essenial for delivery; it allows the body to express an active need of contact through the invasion or conquest of the other's space; it places the genitals in spontaneous and direct contact with the walls of the intrauterine medium; it also allows for the corporal manifestation of aggressive defense or attack reactions. Corresponding with this last statement, there is the fact that the baby, when in physical contact with the adult, tends to corporally express its anger or rebelliousness by tensing itself in

frontal convexity until obtaining a reponse from the other (which I was able to observe this on many occasions with my son, Axel).

All this behavioral data prepare the ground for the hypothesis that in this stage a consistent, spontaneous movement towards the other begins, with the aim of entering the other's space and contacting with the other's body. It is the moment in which the fetus can begin to feel the acceptance of all its body, of its urges to penetrate the space of the other, of its need for gratifying contact.

Clinical Data

The *phallic structure* will use as a clinical example patient "B", who established his main problem to be the imperious and obssessive necessity of sexual contact with women. When he was in a couple-like relationship and a few days went by without making love, he became terribly anxious. If his demands were not met by his partner, he rapidly searched for another woman to make love with. It was an inevitable compulsion due to he fact that it was the only way to reduce his anxiety. But since this situation repeated itself with certain frequency, all his partners wound up leaving him. He himself caused the breaking-off by telling them about his affairs as a way of revenge. With the bitter complaint that no woman could truly love him, he palliated each of his separations.

Around the middle of his fourth year of psychotherapeutic process, he began to enter prenatal regressions. He felt his body to be very tense and stiff, depicting a frontal, semi-opened tension. His back hurt very much, especially the lumbosacral zone. He also felt a sensation of shrinkage in his genitals. In this posture, he only admited corporal interventions to unblock his back. Thus emerged an anger felt in all his body that was expressed striking out with his arms and extensively moving his trunk. From his throat emerged a sharp, desperate, and infantile cry, that contrasted with the strength and virility of the corporal action. Through this type of expression, he went on to contact with the experience of a strong rejection of his body on behalf of the mother, with whom he had always had very little physical contact. He felt himself to be inside a closed, sticky and hard space that surrounded him: the maternal uterus as he himself pointed out. He consented to movement with desire of contact; but when he tried it he was attacked by strong muscular pains, feelings of choking and repulsion. It was as if he couldn't move in any direction without feeling spasms of rejection proceeding from the maternal body. He could only be accepted if he put aside his urge, blocking it out and transforming it into some kind of machanical movement without contact. This was how he became aware of many of his habitual, stereotyped conducts, based on the effort to carry out as perfectly as possible works or actions accepted and praised by others, without ever managing to feel satisfied with the apparent successful results. He understood that what he really wanted deep down was another type of primary, more direct acceptance. He strongly felt the need to be loved affectively and sexually at the same time.

From this moment on, he agreed to undergo therapy with his partner, who was also involved with a deep personal process. In the session with the couple, it was extremely important for him to feel that his body could express his spontaneous movements, his strong urges, painful and agressive as well as sensual, without losing a positive and affective contact with his partner. To see once and again that

she could be there and accept his negative and prohibited emotions allowed him to tranform them into pleasure and plenitude.

We will not give any clinical examples of the *hysteric structure* for reasons of space and time. Leave it to say that in the intrauterine experiences of hysteric, there appears an important differerential fact: the perception from the uterus of the presence and emotional disposition of the father. It is also necessary for him or her, as with the phallic, to feel the acceptance of all his or her body by the mother's intrauterine medium; but clinical data corroborate that he or she intuitively senses, if the father does or does not love the woman, his or her mother, in short, her, completely, affectively and corporally at all the same time.

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