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# Working with Pre- and Perinatal Material in Psychotherapy

## – Invited Paper –

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**Keywords:** Pre- and perinatal psychology; Psychotherapy; Regression; Abreaction; Birth trauma

**Abstract:** The major premise of all insight oriented therapies is that the resolution of unconscious conflicts leads to improved mental health and the disappearance of symptoms. A significant part of this process of "making the unconscious conscious" – as Freud put it almost a hundred years ago – involves the recovery of traumatic events. Until the advent of Pre and Perinatal Psychology therapists who engaged in regressive work, with some notable exceptions, never explored their clients lives before age two. Today, a growing number of therapists do exactly that. These therapists accept the validity of concepts such as cellular memory and the possibility of genuine memories formed prior to birth. I personally believe that two separate but complementary systems serve our memory. One system consists of cellular memory which is based on a holographic model where each cell knows what every other cell knows but also carries some additional information specific to that cell. Cellular memory operates in the sperm, the ovum, and their subsequent union and development. The other system is cerebral memory which depends for its functioning on the establishment of mature neurological networks that comprise the central nervous system. This system is operative by the end of the second trimester i.e. about six months post conception age.

**Zusammenfassung:** *Die Arbeit mit prä- und perinatalem Material in der Psychotherapy.* Die wesentliche Voraussetzung aller einsichtsorientierten Therapien ist die, daß die Lösung von unbewußten Konflikten zu einer verbesserten psychischen Verfassung und zu einem Verschwinden von Symptomen führt. Eine bedeutsame Folge dieses „Bewußtmachen des Unbewußten", wie Freud es vor nunmehr fast hundert Jahren formulierte, ist die Wiederbelebung vom traumatischen Ereignissen. Bis zum Aufkommen der prä- und perinatalen Psychologie explorierten die Therapeuten bei der Arbeit mit regressiven Inhalten mit wenigen bemerkenswerten Ausnahmen nie das emotionale Leben unterhalb von zwei Jahren. Heute tut eine wachsende Zahl von Therapeuten genau dies. Solche Therapeuten betrach-

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ten solche Konzepte als valide, die ein Zellgedächtnis und die Möglichkeit von authentischen Erinnerungen aus der Zeit vor der Geburt annehmen. Ich persönlich bin der Meinung, daß zwei getrennte, aber sich ergänzende Systeme die Grundlage unserer Erinnerung bilden. Ein System besteht aus dem Zellgedächtnis, das eine holographische Struktur hat, bei der das Wissen jeder einzelnen Zelle auch von den anderen Zellen gewußt ist, aber jede Zelle gleichzeitig für sich selbst spezifische Information besitzt. Das Zellgedächtnis ist beim Spermium, beim Ei und in den folgenden Entwicklungsstadien wirksam. Das andere System ist das im Gehirn gespeicherte Gedächtnis, das in seiner Funktion von einem entwickelten neuronalen Netz abhängig ist und das zentralnervöse System umfaßt. Diese System ist zum Ende des zweiten Trimesters funktionsfähig, das heißt etwa sechs Monate nach der Konzeption.

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This bipolar model of memory explains the hitherto mysterious existence of validated memories from before the third trimester, past lives therapy, the Jungian concept of the collective unconscious as well as reports of people declared clinically dead who describe accurately what transpired while they were "gone".

Therapists who subscribe to the new Pre and Perinatal orientation are willing and eager to take their clients on a journey to the dark wonderland of womb life in an attempt to reach and resolve the original or primal traumas that in conjunction with subsequent traumas lead to aberrant development of the client's personality. I think it is important to realize that by rolling back the conventionally held age barrier to the recovery of memories we and those who have preceded us are responsible for initiating a major revolution in Psychology.

I would like to discuss the various approaches to working with material that emerges in the course of psychotherapy and that is felt either by the client or the therapist to be related to pre- or perinatal life. By the word "material" I denote the whole gamut of verbal and non-verbal communications between a client and their therapist manifested in dreams, slips of the tongue, behavior, symptoms, interpersonal difficulties, transference phenomena, etc. In my own psychotherapeutic practice, I am governed by the following eight theoretical principles:

1) Interpretations must be linked to the client's mental processes and not the therapist's.
2) Procrustean interpretations which are based on rigid and unsubstantiated theories tend to produce mindless conformity instead of real understanding. Often they are toxic.
3) Therapists who follow their patients' communications provide a safe and accepting environment for them. Only in such a relationship can patients finish the unfinished business of the past.
4) Intellectual insight unless accompanied or followed by emotional insight is of little benefit.
5) If one aims for a deeper reconstruction of the psyche it is essential that the client make some changes in his real life. Internal and external changes need to go hand in hand. It is impossible to achieve one without the other.
6) When working with dreams it is best to keep in mind the old, onion peeling metaphor. Start with the outer layer of here and now reality and gradually

progress towards the core. As you do you will pass through the Freudian, the Jungian, the pre and perinatal and finally, the transpersonal layer.

7) No one technique works with every person. Therefore, a therapist must be prepared to experiment with a smorgasbord of approaches such as hypnosis, guided imagery, rhythmic breathing, body work and other simulative and evocative methods.
8) Consideration of pre or perinatal traumas without an exploration of subsequent traumas is as incomplete as psychotherapy that neglects the pre and perinatal period.

**Introduction**

I would like to discuss the various approaches to working with material that emerges in the course of psychotherapy and that is felt either by the client or the therapist to be related to pre- or perinatal life. By the word "material" I denote the whole gamut of verbal and non-verbal communications between clients and their therapists manifested in dreams, slips of the tongue, behavior, symptoms, interpersonal difficulties, transference phenomena, etc.

The major premise of all insight-oriented therapies is that the resolution of unconscious conflicts leads to improved mental health and the disappearance of symptoms. A significant part of this process of "making the unconscious conscious" – as Freud put it almost a hundred years ago – involves the recovery of traumatic events. Until the advent of Pre- and Perinatal Psychology, therapists who engaged in regressive work, with some notable exceptions, never explored their clients' lives before the age of two. Today, a growing number of therapists do exactly that. These therapists accept the validity of concepts such as cellular memory and the possibility of genuine memories formed prior to birth. I personally believe that two separate but complementary systems serve our memory. One system consists of cellular memory which is based on a holographic model where each cell knows what every other cell knows but also carries some additional information specific to that cell. Cellular memory operates in the sperm, the ovum, and their subsequent union and development. The other system is cerebral memory which depends on the establishment of mature neurological networks that comprise the central nervous system. This system is operative by the end of the second trimester i.e. about six months post-conception age.

This bipolar model of memory explains the hitherto mysterious existence of validated memories dating from the second trimester, past-lives therapy, the Jungian concept of the collective unconscious as well as reports of people declared clinically dead who describe accurately what transpired while they were "gone".

Therapists who subscribe to the new Pre- and Perinatal orientation are willing and eager to take their clients on a journey to the dark wonderland of womb life in an attempt to reach and resolve the original or primal traumas that, in conjunction with subsequent traumas, lead to aberrant development of the client's personality. I think it is important to realize that by rolling back the conventionally held age barrier to the recovery of memories, we and those who have preceded us, are responsible for initiating a major revolution in psychology. However, in

the process of supplanting the old order we run the risk of establishing a new and narrow orthodoxy of our own.

For example, not every patient who dreams of descending a staircase, being trapped in a sewer or trying to open a locked door is reliving his birth. Not all memories of conversations overheard between parents while the patient was still in the womb are authentic. Therefore, we need to ask ourselves: How do we apply our new understanding of the mental and emotional life of the unborn child in a rational and responsible way to the healing of pre- and perinatal wounds in children and adults?

Unfortunately, we lack "scientific" guidelines for establishing a psychotherapeutic intervention as being either correct or incorrect. One of the objectives I hope to accomplish in the course of this discussion is to arrive at some criteria that would define sound psychotherapy based on an exploration of pre- and perinatal issues. Here is an example of what I consider unsound psychotherapy in this area.

One of my patients told me that her former psychiatrist interpreted all her dreams that dealt with her father, mother or husband as her wishing these people dead so that she could be alone and suffer just as she did when she was born and placed in an incubator.

This kind of interpretation does not in any way relate to the patient's own mental life. She did not wish her parents or husband dead. She had absolutely no desire to return to the isolation of the incubator. Even if the interpretation had been correct, and this is the second problem with an instant prefabricated interpretation, she would not have benefited from it because she was not ready to accept it. The therapist's comments were rejected by the patient intellectually though emotionally they caused her a lot of anxiety. In this particular case, the patient became progressively worse. Her therapist told her that she needed to get worse before she could get better. You can see here the workings of a closed system that can gradually grind down any resistance.

To me this represents an excellent example of ideologically-driven psychotherapy. By this I mean that the therapist has some predetermined and strongly held notions about psychotherapy and whatever the patient says or does is made to fit into this ideological grid regardless of the patient's own reality.

## The Gestational Model

There are several ways in which one can conceptualize and work with material that emerges in the course of psychotherapy. We shall study two of these. One uses a Gestational Model and the other applies known therapeutic schools or systems to it. We shall turn first to the Gestational Model which consists of five stages as follows:

1. Primary Germ Cell Stage
2. Conception Stage
3. Oviduct Stage
4. Implantation Stage
5. Uterine Stage

I shall discuss each stage in terms of the major contributors to our knowledge of it, the symbolic expression in sensations, images, symptoms, etc. peculiar to that stage of development and my own theoretical orientation and clinical approach.

*1. Primary Germ Cell Stage*

The very first paper that ever dealt with the psychology of conception was written by a virtually unknown analyst, Sabina Spielrein[29]. It was called "Destruction as a Cause of Coming into Being" and was delivered in Vienna in 1912 to the small circle of analysts around Freud. It is a paper at least 50 years ahead of its time and I think that even today it could be studied to advantage.

Spielrein argues that in the fusion of the two gametes both destruction and new creation occur. The male segment becomes dissolved in the female while the female segment becomes disorganized and takes on a new shape through the alien intruder. The change in structure hits the whole organism. Destruction and reconstruction, which ordinarily happen slowly and cyclically, here happen abruptly.

Spielrein believed that it would be unlikely if the individual did not at least sense these destructive and reconstructive processes.

The first person who attempted to systematically chart the unknown territory of intra-uterine life was the brilliant Scottish psychiatrist R.D. Laing. In his groundbreaking book, *The Facts of Life*,[14] Laing writes, "It seems to me credible ... that all our experience in our life cycle from cell one is absorbed and stored from the beginning, perhaps especially in the beginning. How that may happen I do not know. How can one generate the billions of cells that I now am? We are impossible but for the fact that we are."[15] Later he asserts, "It is at least conceivable to me that myths, legends, stories, dreams, fantasies and conduct may contain strong reverberations of our uterine experience".[16] The connection between prenatal and perinatal experiences and myths, fairy tales and art expression has been explored extensively by Lloyd DeMause[5], Michael Irving[10], Thomas Verny[30], and Ludwig Janus[12] and due to limitations of time will not be discussed here.

The late Graham Farrant has spoken eloquently on cellular consciousness. He has shared his own experiences and those of his patients starting from just before fertilization to birth. At the Atlanta PPPANA (now APPPAH) Congress (1991), he discussed the mutual attraction between the ovum and one particular sperm which the ovum seems to select from the ones courting it. His concepts were based not only on clinical case material but also on detailed photographs of the ovum-sperm encounter that leads to conception.

*2. Conception Stage*

Isador Sadger[28] wrote in 1941 that it makes a difference under what emotional conditions the spermatozoon is expelled and how it is received by the ovum. Sadger believed that it is to the benefit of the individual if sexual congress is accompanied by feelings of sensuality and love and if the ovum receives the sperm with "open arms".

Sadger quotes one of his patient's in therapy as saying, "I had a penis earlier, namely, the umbilical cord. After birth it was gone. This castration I can never forgive my mother."

In Greek mythology, we are told of a highway robber, named Prokroustes who would offer wayfarers hospitality under the condition that they fit exactly his bed. Since most travelers were either too short or too long, he stretched the short ones and cut the legs off the tall ones, killing them in the process. To me the above interpretation based as it is on rigid and unsubstantiated theories is Procrustean in nature. Interpretations such as these produce mindless conformity instead of real understanding.

This brings me to another point about psychotherapy. Intellectual insight, unless it is also accompanied or later followed by an emotional insight, does very little to produce a real shift in personality. Any technique which helps clients to contact their feelings or their bodies will facilitate emotional insight.

Several years ago I recall working with a 45 year old man who complained of feeling angry. I encouraged him to go deeper into his anger, to become his anger. I will describe what happened in the present tense.

John identifies his rage as belonging to his father. He feels part of his father's desire for wanting to have sex with his mother. Next, he feels his mother's passivity and rejecting attitude towards his father. He feels the clash between father's aggression and his mother's coldness and vulnerability. On talking about this experience it becomes very clear to him how all his life he has been struggling to overcome these same impulses in himself. He is one of the most ambivalent people I know. Introspection and psychotherapy are his life. Suggestions to alter his lifestyle are ignored or met with hostility.

In my experience, clients who are not willing to alter their lifestyle, to practice new ways of being and relating, in other words, expend some energy and take some risks in real life will not change on a deep level.

*3. Oviduct Stage*

Many adults discuss their body image or have dreams in which they experience themselves as:

A sphere, a ball, a balloon, hollow, with no arms, no legs, no teeth. They will say, "I do not feel myself to have a front, back, up, down, or laterality. I float, fly, spin. Sensations come from everywhere. It is as though all I am is a spherical eye."[14]

*4. Implantation Stage*

Most embryologists now believe that 50% of fertilized ova are aborted between the time of conception and the first few days after implantation. This very high rate of miscarriage is largely due to the fact that one half of the proteins in the blastula are from the sperm. The sperm is by the rules of the immune system tagged as a foreign body. Therefore, the endometrium reacts to the blastula as if it was an alien invader and mobilizes its defensive forces in an attempt to defeat it. Depending on the outcome of this struggle the blastula either dies or succeeds in establishing a foothold, usually in the posterior wall of the uterus.

These physiological events may be experienced psychologically as a battleground analogous to conception. They may serve as the template for the feelings of pleasure associated with pushing, getting ahead, diving fearlessly into things, exploring new horizons with confidence or with trepidation, always moving cautiously ahead (putting feelers out – chorionic villi?). Many people spend their lives trying to get into a club, a fraternity, a university or

a group of friends. They have dreams of quicksand, swamps, storms, winds, shipwrecks, breaking into pieces. They may complain of an inability to get into what they are doing, suffering from unexplainable fatigue, lack of willpower and intellectual impotence.[17]

R.D. Laing who treated many severely disturbed patients relates the following two conversations that seem to reflect on the pull of the implantation struggle on the patient's present feelings.

Client A: I feel
I am
clinging to crumbling rocks
liable to be swept away
in the torrent,
hanging on for dear life,
trying to get a foothold,
never seeming as though
I can get into what I'm doing.

Always trying to get in.
Everything glances off me.
I feel in a whirl
as though I'm turning round
and round faster and faster
and I could whirl away forever.[18]

Client B: I feel like a sponge.
A deep underwater creature
like an anemone.
I'm sodden with terror
suffused with fear,
a terrified sponge.
I'm helpless.
I can't move. It's meaningless to get out of it by
running away,
talking
I'm quivering all over.[19]

*5. Uterine Stage*

Since the early days of Freud, orthodox psychoanalysts have held fast to the belief that any dreams about or recollections of prenatal events were fantasies due to "retrojection." A number of analysts beginning with Otto Rank[24], Nandor Fodor[7], Francis Mott[21], Lietaert Peerbolte[22], Gustav Graber[8] and Friedrich Kruse[13], to name but a few, deviated from this party line and had to suffer the unpleasant consequences. The problem with the work of these true pioneers was that, though they ascribed much more mental capacity to the unborn than their contemporaries, they never really freed themselves of psychoanalytic dogma. They simply recycled all the old concepts so that, for example, the Oedipus complex became a competition between the sperm and the father for the love of the ovum or, the loss of the umbilical cord at birth became equated with castration. Thus, we were still left with Procrustean interpretations, stretching or truncating the truth.

## The Psychotherapy Model

### *Abreactive and Feeling-Oriented Therapies*

Wilhelm Reich[26] developed his orgone therapy in the 1930s in an attempt to circumvent the rational mind and its resistance by working on the body. It was later modified and extended by Alexander Lowen[20] in his writings on Bioenergetic Therapy. At about the same time, Eva Reich[25], who attended the first PPPANA Congress in Toronto in 1983, started to elicit repressed memories by deep tissue massage of adults and children.

Natal Therapy was originated by Elizabeth Fehr in the 1970s and her daughter Leslie Feher popularized it with her book, *The Psychology of Birth*.[6] Natal therapy attempts to wed individual, verbal psychoanalytic sessions with an intensely emotional, non-verbal group rebirth.

The best known body-oriented regressive abreactive therapy is Arthur Janov's Primal Therapy. Unlike Feher, Janov[11] discourages intellectualizations and interpretations and stresses the total reliving, which he calls "primaling", of early traumatic events. Similar to Feher, he builds expectations in his patients and uses a wide variety of techniques from isolation to body work to intensify their feelings. Janov has written extensively about the importance of working with people from inside out instead of from outside in. Techniques such as hitting a pillow to put a client in touch with her anger or crawling through a tunnel of mattresses to simulate birth would be examples of techniques imposed from the outside. What Janov advocates is enhancing feelings that emerge organically from the client rather than imposing therapist's interpretations or therapists' techniques on the patient.

In my experience, primal patients, more than any other patients, are extremely well informed about the therapy. They have all read one or more of Janov's books and by doing so come to expect major emotional reactions while undergoing this form of therapy. Contrast this with your average psychotherapy patient who at best has read a bit of Freud or Jung but has no idea what to expect in psychotherapy. Thus, we have several factors operating in these therapies which make the results suspect. These are: subtle prior indoctrination, group pressure to conform and the need to become part of an inner circle of idealized authority.

Personally, I prefer to work with people who enter therapy without any preconceived notions about therapy. I do very much support Janov's inside-out principle, the need to re-experience past events as fully as possible and to avoid intellectualizations. There is no doubt in my mind that any technique that is body-oriented and appropriate to what the client is experiencing in the moment will facilitate therapeutic progress. Unfortunately, not all patients are open to be worked with in that way and not all therapists are comfortable working in this manner.

### *LSD-Assisted Therapy*

Stanislav Grof[9] has applied his psychoanalytic training in the service of LSD-assisted therapy and holotropic therapy. I believe his major theoretical contribution is his discovery of what he calls the four "perinatal matrices" of consciousness. His first matrix, "symbiotic unity", refers to feelings and memories from the time before the onset of labour, the "antagonism" matrix occurs at the onset of labour;

this is followed by "synergism" as the baby moves forward in the birth canal and finally, "separation" when the baby is born.

I would recommend that all therapists working in an insight-oriented way familiarize themselves with the relationship between certain symptom clusters and perinatal matrices. I think this knowledge will considerably improve their ability to help clients with problems that originated at birth or prior to it.

### *Hypnosis*

Next, I would like to discuss hypnosis as a method of investigation, memory retrieval and therapy. The two major figures in this area are David Cheek and David Chamberlain. Cheek[2,3] has described his ideo-motor approach to hypnosis in many papers and books. Essentially, it consists of a brief hypnotic induction using a pendulum followed by a suggestion that in response to a question to which the answer is affirmative, one of the patient's fingers move. When a finger moves, it is designated the "yes" finger. This is followed by identifying the "no" finger and the "I'm not ready, yet" finger. Sometimes during questioning the patient's hands will drift off into unusual positions and other kinds of spontaneous movements. The therapist can facilitate whatever is involved somewhat as follows:

> Sometimes the unconscious can tell a story with movement ... sometimes it becomes clear what that is about ... There may or may not be images, memories, thoughts, voices, or feelings associated with those movements .... As that continues, you may begin to experience certain feelings more (or less strongly) ... simply allowing that to continue all by itself until you know ... Allowing the creative healing forces (inner mind, higher self, etc.) to continue in just that way, until the inner work is completed for now .... And as those hands finally come to rest (when it is obvious that they are), your unconscious can make available just one or two thoughts that we need to understand so that we can further facilitate the healing next time.[27]

Chamberlain has used more conventional inductions and questioning to obtain a variety of birth and pre-birth reports. Chamberlain[2] writes that:

> A recent critical review of experiments in this field confirmed that hypnotized subjects do have significantly greater recall for both verbal and nonverbal material, provided it is meaningful and is obtained by a method called free recall. Studies show that memory is facilitated, too, when the remembered event contains strong images, emotions, sensations, or meaning. Memories can be spoiled, however, if the interviewer asks leading questions, suggests answers, or uses interviewing techniques that hurry and confuse the person remembering.
>
> Narrative moment-by-moment birth reports are rare, although many people are quite capable of having them. These rather amazing stories have all the advantages of mature language, because babies have grown up. They reveal lucid thoughts and deep feelings going on at the time of birth.

To practice the kind of creative hypnosis that people like Cheek and Chamberlain employ, one needs to possess not only a special aptitude for it but also, a total confidence in its efficacy. Since I have never been hypnotized though I tried several times, I lack the faith necessary to succeed with this method. I also may lack the talent. For these reasons, I have developed a therapy system that does not use hypnosis. I have called my approach Evocative Therapy because of its ability to

evoke memories, sensations and feelings in a gentle, humanistic fashion. I shall describe some of the major elements of evocative therapy below.

*Evocative Therapy (author's own approach)*

The people I see in my practice may be divided into two groups. In Group A are the patients who consult me for a variety of symptoms such as anxiety, depression, psychosomatic disease, sexual dysfunction and the like. In the course of their psychotherapy, some material may emerge, most frequently in dreams, that I feel may have pre- or perinatal origins. Group B consists of clients who enter therapy because they either wish to recall some earlier traumatic event such as the in-utero death of a twin or who have specific problems related to pregnancy or the wish for pregnancy. While I work the same way with all my patients, I am more goal-directed and past-focused with people in the second category. Because I believe that in order to undergo any real change patients must live therapy 24 hours a day, seven days a week or, at least a lot more than fifty minutes once a week, I tape all our sessions on an audio tape. Patients are requested to listen to this tape at least once prior to their next session. Patients are also asked to keep a journal. In the journal they are to write down thoughts or feelings that they had following their session. In addition, any dreams, any emotionally charged events either of a positive or negative nature that occur during the day and any flashbacks to childhood or beyond are to be entered in the diary. In this way, clients are taught right from the start to take an active part in their therapy instead of looking to the therapist as the person with all the power and magic.

When I work with dreams I usually do so on four levels. The first is the here and now reality level. Thus, if the client was a woman called Anne who dreamt that she had an argument with her boss, Peter, we would first examine her relationship to her boss. When that subject was exhausted, I might proceed to the second, Freudian, level. For example, if the boss was an older man who reminded her of her father we could investigate some of Anne's ambivalent feelings towards her father and, perhaps, her relationships with men in general. From here we could proceed to the third, Jungian level, and identify the boss as representing her animus or masculine aspect. Often a good way of reaching this third level is to employ the Gestalt technique introduced by Frederick Perls.[23] If the client was willing to try that approach, I would place an empty chair in front of Anne and ask her to sit in it and become her boss, Peter. When she felt sufficiently immersed in being Peter I would ask her to speak as Peter to Anne. When Peter went as far as he could, I would ask the patient to move back into her chair, become herself again, and respond to what Peter had just said. We would switch roles back and forth until we reached a resolution or an impasse. By watching for and refocusing the patient on changes in breathing patterns, the appearance of inappropriate facial expressions or bodily movements such as a sudden shifting of the foot, or expression of emotions like crying or clenching of the fist, one can reach an even deeper pre- or perinatal layer. Usually, with questions such as "What are you experiencing right now?" or, "What does your right fist want to do?" the therapist can facilitate the reliving of some very early traumas.

When a patient wants to uncover forgotten memories, I routinely employ the technique of guided imagery.* I have found that I obtain better results with guided imagery if the patient is in a receptive and relaxed state. To achieve this, I practice the well known progressive muscular relaxation formula. While I instruct the client to tense a muscle group such as the calves or the thighs, I also insert suggestions of a hypnotic nature such as: "With each breath that you take, you are choosing to go deeper and deeper into a perfect state of relaxation," or, "As you become relaxed, you will pay less attention to your analytical left brain and you will connect more with your feeling right brain. Let any old feelings or memories that you want to re-experience gradually rise to the surface of your awareness." For all intents and purposes, this type of approach is a hypnotic induction but it avoids non-compliance. Very few patients are so resistant that they cannot follow these simple instructions.

When a sufficient state of relaxation has been achieved I can take the person back to their conception or any point along their intra or extra-uterine life by simply saying: "Go back now to the time in the womb when you first heard your mother argue with your father," etc. Or, I can start with an accurate description of the physiological events of conception, journey down the oviduct and implantation. It would sound something like this:

"One single round egg is floating in the oviduct surrounded by a dozen or so sperm cells. They are all swimming as fast as they can towards the egg. As you look at this scene which of these cells do you connect with? Is it one particular spermatozoon or is it the ovum? Notice your reactions. Do you have any sensations, feelings or thoughts right now? Very soon one of the spermatozoa reaches the ovum and enters it. Try to see this as clearly as possible. What does it feel like?"

In this way, I could move on to implantation and the first trimester. At that point the patient could be asked to return into the present, to sit up and to talk about his experiences. In the next session, we could repeat the procedure but start where we left off in the regression, that is, in the above example, at three months.

One can access repressed memories more indirectly by first engaging in progressive relaxation and then by saying: "Now I will play some classical music for you. When the music starts please allow the music to take you wherever you need to go. Do not think, do not try to analyze or appreciate the music. Just feel it the way you would feel the rays of the sun on a warm summer day, open yourself up to the experience and go with it." All suggestions are made in a low, melodious voice with lots of pauses and references to what the patient is doing. If, for example, the patient shifts his body, I'll say: "That's right, get more comfortable so that you can really relax and go further back in time."

If clients have few or no definite images or feelings during the music regression, I will hand them a large sheet of sketching paper and a box of crayons and ask them to draw their experience whatever it was. It's really quite astonishing how much pre- and perinatal symbolism emerges in the process.

Other ways of evoking memories of womb life are: showing clients slides or movies of prenatal development or asking clients to look at illustrations in books

* For a thorough discussion of this and related techniques, see Nurturing the Unborn Child, Thomas R. Verny, MD, and Pamela Weintraub, Delacorte Press, New York, 1991.

like Lennart Nilsson's *A Child is Born*. Attending a birth can also be a powerful trigger of one's own birth memories. And, of course, becoming pregnant often leads to the emergence of pre-birth memories.

I have found these techniques to benefit infertile couples, women with frequent miscarriages, women wanting to contact their babies before terminating the pregnancy, women planning to relinquish their babies for adoption and men and women with a variety of symptoms which they themselves diagnosed as having been caused by pre- or perinatal traumas.

**Psychotherapeutic Interventions**

In the course of this paper we examined psychotherapeutic interventions which were used to facilitate the recall of pre- and perinatal memories or that were employed with material that emerged in psychotherapy and seemed to relate to a client's pre- or perinatal life. In my own psychotherapeutic practice, I am governed by the following eight theoretical principles:

1) Interpretations must be linked to the client's mental processes and not the therapist's.
2) Procrustean interpretations which are based on rigid and unsubstantiated theories tend to produce mindless conformity instead of real understanding. Often they are destructive.
3) Therapists who empathetically respond to their patients' communications provide a safe and accepting environment for them. Only in such a relationship can patients finish the unfinished business of the past.
4) Intellectual insight unless accompanied or followed by emotional insight is of little benefit.
5) Depth-oriented therapy is not a theoretical past-time. Therapy, to succeed, must lead to changes in behavior, attititudes, interpersonal relationships and lifestyle. Internal and external changes need to go hand in hand. It is impossible to achieve one without the other.
6) When working with dreams it is best to keep in mind the old, onion peeling metaphor. Start with the outer layer of here and now reality and gradually progress towards the core. As you do you will pass through the Freudian, the Jungian, the pre- and perinatal and finally, the transpersonal layer.
7) No one technique works with every person. Therefore, a therapist must be prepared to experiment with a range of approaches such as hypnosis, guided imagery, rhythmic breathing, body work and other simulative and evocative methods.
8) Consideration of pre- or perinatal traumas without an exploration of subsequent traumas is as incomplete as psychotherapy that neglects the pre- and perinatal period.

**Summary**

This paper is an attempt at a historical survey of psychotherapies that have successfully accessed pre- and perinatal memories. A variety of ways in which psychotherapists today work with material that is felt by the therapist or the client to

be linked to pre- or perinatal life are discussed. Therapists working in this area will benefit from a thorough understanding of the developmental stages of prenatal life.

The author is critical of rigid, theory-driven therapeutic interventions which he refers to as Procrustean, while favoring client-friendly and client-centered interpretations.

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