

Prenatal and Perinatal Psychotherapy with Adults: An Integrative Model for Empirical Testing

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ABSTRACT: This article identifies an issue within the discipline of prenatal and perinatal (PPN) psychology, namely that the field currently consists of individual practitioners' modalities without empirical validation around treatment efficacy. The goal undertaken was to integrate the PPN literature related to adult psychotherapy into a coherent and practical model to serve as a guide for students and professionals that could also be empirically tested. Covered briefly is a review of the historical and pivotal literature, a description of theory, an assessment process, PPN treatment plan, techniques to facilitate access to PPN memories, and two illustrative excerpts from sessions as examples. Finally, suggestions for methodologically testing the model are offered.

KEY WORDS: Prenatal, perinatal, adult, psychotherapy, trauma, consciousness, intervention

INTRODUCTION

Despite the increase in prenatal and perinatal psychology (PPN) literature during the last quarter century, the field has not yet articulated an integrated PPN-specific model of psychotherapy with adults. What has developed are a number of individual practitioners' modalities, which have added a basic understanding and depth to our knowledge. However, few of these modalities integrate the building literature and none have been studied empirically. As the Program Chair of a graduate school guiding students toward becoming PPN practitioners, this situation is problematic. It is made more so by the fact that mainstream psychology has made a concerted effort to succinctly articulate graduate curriculums around a specific theory, which then guides the assessment process, treatment planning and appropriate therapeutic techniques. This paper attempts to begin a discipline-wide conversation about what a PPN psychotherapeutic assessment and treatment plan might contain by offering a model that draws on the PPN literature. Also included in this model will be the more recent developments from a number of related disciplines that are currently impacting the clinical aspects of PPN therapy today, namely, the relational aspects of therapy from the neurobiology and attachment literatures, and a renewed emphasis on the importance of the body (somatic cues to early experience).

DEFINITIONS, BASIC ASSUMPTIONS, LIMITATIONS

Definitions

A definition for PPN psychology is that it views impactful events, which occur from conception through the prenatal and perinatal (birth) developmental time periods, as

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having profound and lasting psychological effects. PPN psychotherapy is defined as the treatment of the sequela of the deeply imprinted events, because without intervention unresolved early traumas have the potential to become maladaptive and repetitive patterns in adulthood.

Assumptions

This prenatal and perinatal paradigm's primary tenet is that the developing child is capable of sensing, experiencing, and remembering as a conscious, aware being, thus able to experience stressful events while in utero. That is, the prenatally is conscious of the events experienced (especially those that are traumatic for psychotherapeutic purposes) and retains primitive imprints of events. These imprints will have cognitive, emotional, relational, and somatic (body) sequela as well that will continue into adulthood, and in all likelihood, if the early event was seen as intolerable or overwhelming by the unborn child, the memory of it will be forced out of consciousness.

Limitations

The literature review in this article is far from exhaustive, yet the reader is encouraged to explore the various topics listed, using the references as a guide if more depth within these topics is of interest. This review will not include the literature of the PPN therapeutic work with infants or children and their families. While the PPN assumptions are the same in working with this younger subset, developmental issues makes the infant/child model unique and will not be developed here.

A BRIEF HISTORICAL REVIEW

Remarkably, there are few references to the importance of events during the prenatal and perinatal periods in recorded western history before the 20th century. This section will cover a brief historical review of the major authors who contributed groundbreaking works in the early-to-mid twentieth century.

Beginnings

In 1923, Otto Rank wrote *The Trauma of Birth* in which he suggested that birth anxiety is the prime source of adult neuroses and character disorders. Frank Lake (1966) conducted research into regressive therapies and concluded that patients can relive their birth trauma. Arthur Janov, creator of primal therapy, also a type of regressive psychotherapy, came to observe that the developmental periods of birth and before are the most crucial in the onset of the pain adults carry with them throughout life (Janov, 1970).

A BRIEF REVIEW OF THE PIVOTAL LITERATURE

This section reviews the pivotal PPN literature, which supports a therapeutic modality with adults. First, there will be a brief review on the foundational principles and the

clinicians who developed them. Next, several of the PPN therapeutic techniques are listed, as well as a typology of adult behaviors due to early trauma, the identification of cognitions and emotions in the therapeutic process, and illustrative studies. Following this will be a look at some of the literature developed from the neurobiology research of the 1990s that points to the fact that the brain is shaped by experience even pre and perinatally. Finally, the body psychotherapy literature is mentioned, as that discipline holds the importance of being with the body's pain in the conscious present moment as another useful way to access the prototypic PPN imprints.

Developing PPN Literature

The discipline of PPN psychology continued to emerge in the latter half of the 20th century from the lessons clinicians gleaned about their clients' earliest life experiences, again via regression techniques, mostly through hypnotherapy and psychodynamic approaches. The field's founding fathers observed that when in a state of regression clients were able to recall traumatic experiences they had during the prenatal and perinatal period that were the first experiences of their enduring emotional and behavioral difficulties (Chamberlain, 1988; Cheek, 1986; Emerson, 1998; Lake, 1981; Verny, 1994). Thus, becoming conscious and integrating early pain in a way each individual client can tolerate was seen as the way to decrease debilitating symptoms.

As the exploration of PPN psychotherapy techniques around regression continued, the methods of treatment could best be described as individual practitioners working with, and reporting on, their clinical cases. As stated, early therapists began by working with adults using hypnosis (Chamberlain, 1988; Cheek & Le Cron, 1968), regression through following the client's lead (Winnicott, 1958), rebirthing methods (Ray & Orr, 1983), primal therapy or reliving of early traumatic events (Janov & Holden, 1975; Janov, 1983), breathwork (Grof, 1975, 1985), primal integration (Lake, 1981, 1982), examining symbolism (Laing, 1976), psychoanalytic methods (Feher, 1980), evocative therapy (Verny, 1994), trauma release techniques (Givens, 1987), holding therapy (Welch, 1983), guided imagery (Verny, 1991), and the use of spontaneous memories (Zimberoff & Hartman, 1998) or a combination of these (to name a few). Psychoeducation was included to give a conceptual framework for reaching the deeply held prenatal and perinatal memories. Several therapists had also developed models for working with infants and families (Castellino, 2000; Emerson, 1989; McCarty, 2002) with the goal of early intervention and prevention, and while not within the scope of this paper, these clinicians clearly belong in any discussion around the building of PPN psychotherapy. More recently, a set of guidelines for establishing psychotherapeutic intervention during these prenatal and perinatal periods was developed by Thomas Verny (1994), emphasizing the importance of integration.

Even with this urging from Dr. Verny, there have been no empirical investigations of an integrated PPN psychotherapy model with adults. However, there have been research studies that clearly point to the need for this approach. One of the most compelling quantitative investigations on the long-term effects of early trauma was conducted by Jacobsen, Eklund, Hamberger, et al. (1987). Jacobsen and his colleagues wanted to examine obstetrical procedures and later adult behaviors. Scandinavian birth records were gathered for 412 forensic victims comprising suicides, alcoholics and drug addicts born after 1940, and who died between 1978-1984. The results showed a striking similarity

between conditions at birth and eventual deaths, specifically, suicides involving asphyxiation were closely associated with asphyxia at birth, suicides by violent mechanical means were associated with mechanical birth trauma, and drug addiction was associated with opiate and/or barbiturate administration to mothers during labor. Although tragic, this apparent duplication of early experience may be the way the developing brain organizes itself in an attempt to understand and adapt to the world it faces, according to these investigators.

Another research example using a qualitative approach is a case example offered by Hendricks and Hendricks (1987). The participant was a 27-year-old who sought therapy because of attacks of anxiety that occurred only under certain situations (airport concourses and shopping malls), which led back to events where she was stuck in the birth canal.

As the PPN literature has grown, several methods of identifying early traumatic events still playing out in the life of the adult client were further delineated. Some examples of this exact recapitulation of early patterns were placed in a typology by Ward (1999) and are illustrative here: adults who feel the need to arrive early and/or may never feel ready for anything (*early or premature births*); adults who tend to wait for things to be done for them, experiencing a lack self-empowerment (*Caesarian section births*); adults having a tendency to have trouble getting started on their own (*induced births*); adults who have difficulty finishing tasks on their own and resent others doing the job they know intuitively is correct (*forceps birth*), and so forth. Other authors have described prototypic events impacting later behaviors during the prenatal period as follows: adults who survive having feelings of dread and being annihilated (*abortion attempts*; Sonne, 1997), and adults who demonstrate immobilization and survival responses, (*prenatal physical trauma*; Riley, 1986). In a previous journal article I had hypothesized that *somatization symptoms* could potentially reflect prenatal expressions of emotional pain or distress manifested through the body (Lyman, 1999). These descriptions are helpful to the PPN psychotherapist, yet the literature also identifies the importance of cognitions and emotions with which the adult client presents.

Some ways of identifying a recapitulated pattern in adult clients within the PPN literature have been through listening to their use of words and language. Cognitive material related to traumatic birth events are illustrated as follows: Being held back or pulled out by forceps (“I have no rights” “I’m out of control”), suctioned (“I need to be rescued”), anesthetized (“I am numb” “I can’t make it without drugs”), induction (“I’m a failure at performing”), and medically indicated caesarians (“I have to rely on other people” “Life is about violence”) (English, 1993).

Powerful emotions have been described as an important part of the therapeutic equation, that is, identifying the emotional connection between the client’s present difficulties and unresolved prenatal and perinatal event(s). The literature has described useful ways to think about clients’ cognitive descriptions and their emotional meanings in three levels (Emerson, 2001), for example, one level would focus on issues related to the present (“I had a big argument with my spouse.”), then at a deeper level, issues of childhood that are emotionally-laden (“I’m deathly afraid that he’s/she’s going to leave me.”), and finally, at the most primitive level, body movements that replicate the early prenatal and perinatal experience and can be seen as a thread through other experiences or levels the client has described with statements such as, “No, no, please don’t leave me...I’ll die if you leave me here.”

Prenatal trauma themes reflected in cognitions and emotions tend to be subtler in their presentation than birth ones, such as the client describing longstanding feelings of being unwanted or unloved with a cognition of “I’m not good enough.” Other impactful events that can negatively influence the prenatate are all of the emotional factors that can be present in the mother. These could include intense grief due to previous miscarriages or abortions, anger or stress from marital problems or a lack of social support, and fearfulness around the baby’s health.

Neurobiology Literature

Looking at the brain to discern where early imprints reside is not new and did not begin with neurobiological researchers during the decade of the brain (the 1990s). Arthur Janov and E. Michael Holden (1975) described their research where they examined where trauma resides in the brain as well as how this early primal pain is processed, traversing all levels of consciousness. More recently, neurobiology has offered new ways of understanding the psychological imprints of the prenatal period as being relational in nature. Schore (2002), for example, has pointed to the importance of the “first” relationship (mother-fetus dyad) regarding prenatal emotional attachment/malattachment during the third trimester. Other PPN researchers have described the attachment dynamic as beginning during the entire prenatal period as a developing relationship (Doan & Zimmerman, 2003) where the contextual issues (situational and personality) and the mother’s emotional state are crucial (Zimmerman & Doan, 2003). It is this early relationship that is being reflected within the therapy setting that is important for the PPN adult therapist to be aware of, along with the knowledge that early imprints are visible both consciously and unconsciously.

Somatic Literature

Interestingly it was again Dr. Janov (1973) who demonstrated how the body was involved in both pain storage and symptom release by photographing patients whose bodies recreated the physical sequela during a birth primal (bruising). These physical markers are what make the somatic literature important to a PPN psychotherapist. A number of other body psychotherapies (Reich, 1949; Lowen, 1967) have added to the awareness around this developmental period because, as they also point to the body as a repository of many of the early, highly emotionally charged events. Integrating this into a PPN psychotherapy means that it would be important to observe and note a change in the client’s physical body (i.e., looking for physiological, muscular memory). There could also be changes in breathing patterns, changes in body positions (rubbing the forehead, or making a fist, or wanting to lay on the floor), especially those connected with changes in depth of emotions (crying, becoming angry). One recent article has described a natural affinity between the somatic discipline and prenatal and perinatal psychology, especially in working with adults around traumatic birth events (Rand & Caldwell, 2004).

Summary

This literature review has by no means been exhaustive. It does serve to focus on the pivotal aspects of the disciplines of prenatal and perinatal psychology: neurobiology as it

applies to the brain during this developmental period, and somatic psychology as another avenue to access early traumatic events. The next section will provide a formalization of a treatment model for PPN psychotherapists to work with adults. It will begin with a broad overview of the PPN theory, the assessment process, treatment planning, and therapeutic techniques.

OVERVIEW OF THE THEORY THAT GUIDES ADULT PSYCHOTHERAPY

PPN psychology theory holds that individuals' experiences from the moment of their conception can have profound and long-lasting psychological effects. The theory maintains that the developing pre-nate is capable of sensing, experiencing, and remembering events as a conscious being and, as such, is able to suffer stressful events while in utero and during birth. The aim of PPN psychotherapy with adults then is to uncover and examine these deep, primitive imprints in order to resolve early traumas that have led to maladaptive, repetitive behavioral patterns.

PPN ASSESSMENT PROCESS

Prenatal and perinatal therapists would utilize various methods of assessment to learn as much as possible about the client's current distress to determine if it is connected to an early traumatic experience. (Note: PPN psychotherapists would use current best practice methods of psychotherapy initially, then assess for early traumatic imprints.) Some of these methods could include taking detailed life histories, utilizing self-reported testing measures, gathering family member reports, but most importantly by scrutinizing the presenting problem. PPN psychotherapists are particularly interested in listening to their patients' narratives in the assessment process to identify their cognitions through uninterrupted speech, to discern the emotional tone and content of the story, and to note any changes in body states (i.e., movements, tensions) during the initial interview.

When long-standing patterns have been identified, the therapist's main job during the assessment phase is to decide how to use this information to facilitate the client's therapeutic journey. But even though an initial assessment and treatment plan has been made, it needs to be fluid. The initial PPN hypothesis will likely be revised at many points along the way as new information is gathered that gets the therapist and the client ever closer to the exact nature of the origins of the repetitive pattern. It should be noted that this is done most easily by therapists who have re-experienced their own prenatal and perinatal imprints to better prepare for their clients' therapeutic journeys. Finally, therapists using this model are particularly interested in the assessing the resources their clients possess. Exploring the client's ability to self-regulate, take care of themselves (i.e., ask for what they need) is critically important so as not to be overwhelmed by early memories during the integrative process.

PPN TREATMENT PLANNING

In order to get an understanding of the process of prenatal and perinatal psychotherapy, this section includes descriptions of therapeutic activities that begin prior to meeting the client, then suggestions for the first session, middle and ending sessions.

Just before these descriptions some in-session skills, which are seen as highly

important for PPN therapists, will be mentioned. First, just as in the prenatal attachment process, clinicians should “hold” the emotional space. Secondly, they should also utilize other techniques that have been shown to be empirically sound, such as, acceptance (unconditional positive regard), the normalizing the client’s problem, the value of insight, seeing the therapist as a model, etc. (Corsini, 2004). It is further suggested that therapists should not be directive, especially in asking leading questions, offering interpretations, or answers. The therapist should go at the pace of the client (fast or slow), that is, not press for early entry into memories, but let the client guide the process.

Prior to the Initial Session

As an option, following the telephone contact and scheduling of the client, materials that prepare them cognitively, emotionally, and somatically are suggested. This would include a brief psychoeducational description of the theory, research and method of PPN psychotherapy. Three instruments used by this author for this purpose are: (1) The Personality Roots Questionnaire (Verny & Engel, 2000 as included in Verny & Weintraub, 2002), (2) The Early Memories Procedure (Bruhn, 1989), and (3) the Trauma and Attachment Belief Scale (Pearlman, 1996).

At the Beginning of the First Session: Introduction of the Approach

Again, a psychoeducational piece about the model is important for integration and so that the client can be aware that emotionally intense feelings can emerge. In the name of helping the client create many ways to self-regulate it is suggested to have them create a positive memory, a visualization, a meditation, or soothing feeling in their body for them to return to safely during the session.

Additionally, due to the enormous individual variations in each client as they explore their own prenatal and perinatal memories, Verny (1994) suggests informing the client also as follows, “...though helpful in a majority of cases, [prenatal and perinatal psychotherapy] does not work in every instance” to address a client’s expectations. Using a metaphor or visual image to describe the goal of therapy is a useful tool also, namely that “we will examine some more current problems or traumas and work backward so as to integrate each...It’s like peeling back the layers of an onion.” (Note: It is suggested that therapists use an informed consent beyond their traditional professional credentials that acknowledges the prenatal and perinatal model. For an example of the author’s version, see Appendix.)

Prenatal and Perinatal Psychotherapy Treatment Plan

The following is an example of a treatment plan format (Grosso, 2004) that incorporates the important aspects of developing a contract with the client to address very early trauma issues. (It needs to be said that as with other more traditional therapeutic modalities, crisis issues need to be assessed first and the client’s safety--harm to self/others--must be managed using accepted professional practice steps and methods. Once the PPN therapist determines the client is not in crisis, the beginning phase of therapy can begin.)

Beginning Phase – Safety and stability are consciously created by the PPN psychotherapist to establish and facilitate a therapeutic relationship with the client. This would include a space for the client to ask any questions about the PPN model.

Goals

- 1) Establish therapeutic relationship
- 2) Educate about treatment and theoretical model (provide ample bibliotherapy)
- 3) Complete all necessary assessments

Objectives

- 1) Obtain a narrative description, and determine the nature of, the presenting problem (distress)
- 2) Listen for prenatal and/or perinatal (early) themes affecting distress patterns and/or dysfunctional behaviors throughout the sessions (cognitions, emotions, observe body behaviors)
- 3) Obtain a client history (the client's story) with emphasis on repetitive patterns identified within the presenting problem
- 4) Obtain a list of client's successes and strengths as well as failures to establish his/her resources and ability to self-regulate
- 5) Interpret Data
 - a) Identify prenatal and/or perinatal pattern
 - b) Determine if original experience was perceived as life-threatening (level of intensity)
 - c) Make safety and ability to self-regulate a top priority
 - d) Educate client about prenatal and perinatal patterns/dysfunctional behaviors (on self/relationships/environments) identified and describe how changing patterns by client can reduce anxiety and current distress

Middle Phase – Begin addressing the early PPN issues driving the dysfunctional patterns and presenting symptoms. Begin by unfolding the client's prenatal and perinatal patterns in the present, moving through the layers toward the early experiences, always returning to a safe place of self-regulation in the present when necessary. Use the safety and trust of the therapeutic relationship as leverage for facilitating change.

Goals

- 1) Taking the assessment of the client's early patterns, diminish trauma/early experience symptomatology
- 2) Enhance personal and interpersonal well-being

Objectives

- 1) Explore the repetitive problem using regression techniques
- 2) Process negative feelings/emotional reactivity of early issues
- 3) Encourage consciousness on all levels
- 4) Deepen the healthy relationship with the client to maintain safety at deep therapeutic levels
- 5) Assign self-exploration/journal homework /reward functional behaviors

- 6) Examine resistance to change or if no change is occurring reassess pattern/diagnosis

Ending Phase – After alleviation or decreasing of distress of presenting issue(s), client should be prepared for termination (this can bring up issues of termination around birth)

Goals

- 1) Prepare for termination/model a healthy good-bye

Objectives

- 1) Complete all necessary assessments
- 2) Explore, address, and process feelings arising from termination
- 3) Encourage the creation of new healthy perceptual (belief) systems
- 4) Address incomplete expectations
- 5) Extend sessions or create new therapeutic goals, as needed
- 6) Leave option open for future treatment

(Note: This treatment plan is written as a tool for both therapist and client to discuss and mutually agree on.)

PPN THERAPEUTIC TECHNIQUES

A strategy drawing on traditional psychotherapies is a helpful technique for the PPN therapist, but with a specific focus. The technique is to reflect back what the client has said so that the adult client can stay with their PPN cognition or feeling, for example, “You said that you’re really *feeling stuck*...” or “I do understand that you *have a hard time with change*.” Speaking these cognitions in a soft voice and supportive tone as a general rule facilitates and maintains the emotional state as well.

Here’s are some examples of some verbalizations that therapists can say during a session that helps facilitate access to early imprinting:

After the client’s story is told:

- “What is the most meaningful part of the story you just described?”
- “Have you ever felt this way before?”
- “Just close your eyes and sink into that feeling...let whatever comes up just be there.”
“Breathe in a deep and rhythmic manner.”
- (Seeing a change in the client’s body position) “What are you experiencing right now when you want to curl into a ball?” “What do you want to do with your fist?”
- (With relaxation induction) “Breathe, and with each breath, you can choose to go deeper and deeper into a state of safety and awareness. If you choose, notice the memories you have around the time of your mom’s pregnancy or birth...(or) Be aware of the time that you first recall feeling (feeling state client has identified, such as, betrayed, sad, etc.)”
- “May I describe (or show pictures) the human journey from conception onward, and would you notice any reactions you may have?”
- “Let’s see if drawing might bring something to the session.”

- Use of psychodrama techniques (having the client speak to representations of themselves as a fetus, or a parent to whom they can talk to about their feelings)
- Use of metaphors: “Your story is like a rose that never got the soil, sun and water that it needed to grow.”

In summary, this section has focused on a couple of techniques that are designed to help the adult client briefly face the challenging, and formerly below consciousness, thought, emotion or physical sensation in such a way that it facilitates a reduction of the imprinted trauma so that a new state of consciousness can emerge. Yet, it needs to be said that while this method of integration is the goal for therapy, some clients do not need to recall the early event for healing. Often understanding the early patterns becomes a lens, a doorway into the process of understanding their current distressing behaviors. It gives more choice in their daily lives at the very least. The next section will include two segments of clients’ sessions that demonstrate the model of PPN psychotherapy discussed above.

Two Session Segments Illustrative of the Process of PPN Psychotherapy

Case Example #1

The first example is one that illustrates prenatal and perinatal cognitions while the client is in a distressed state talking about his presenting problem (job issues in this case). The main topic of employment is not the critical feature to listen for, but rather the cognitions and the highly emotive state that in this example reflect birth trauma. (These cognitions are from several therapy sessions but always retain the characteristics of the same early imprinted event.) A PPN psychotherapist would observe where the client holds this trauma in his body and would work from the hypothesis that these cognitions reflect a repetitive pattern that has been present life long.

T: (holding a safe space while listening to the client’s story and watching his body)

C: ...I’m inadequate, helpless (tears). I can’t hold a job. I can’t get anything right. That I’m stuck where I am. Where am I going? I’m not getting anywhere. It doesn’t matter what I come up with, it’s not something I can do. I fidget when I try to sit still, it’s like I’m tied down or something.

...I’m getting to a point and I can’t get any further. (On the floor pushing his head against the wall). I just want to break lose and crash through what’s been stopping me. I’m so frustrated. I can’t stand this anymore.

...I’ve got to get out of here. I feel like I’m losing it....There’s so much I could be doing. Being more alive, more active....I get to the point where there’s no hope of making it right again...I felt like they were looking down on me and the hopeless feeling of I’ll never get any better...I’ll never get past this...I won’t do it unless you push me, or help me, do it with me. (pause)

...(anger) What’s gonna happen next? What’s gonna fall next? Something’s gonna happen because of the delay. I want help because I don’t feel I can do anything on my own. I don’t follow through. I don’t want to go back and figure it out. Now, I just avoid anything that hurts. Damned if I do, and damned if I don’t. It really crushes me. Like

complete abandonment. It tears me apart...It just kills me, people are cruel. How could you possible hurt something so precious.

...The fact that I may never achieve anything that is what scares me. I have to believe that 'God is not going to let me down. I know what I love, but I don't trust that I can do any of it. So I don't go in that direction...I just want someone to take care of me.

...What is it that's stopping me? It feels like if they could cut that string and everything would open up, it's like something in my brain is not clicking and if I could do that it would magically happen. I know it's there. I can't do it alone. I want to break through this. I want to understand why I ...what suppresses me. Why am I resisting? I can't do it. I'm at the brick wall. It makes me see how out of control my life is. I can't get away from the feeling. The harder I work to forget the more I'm getting upset. I'm so dependent I can't initiate my own life. A roadblock in front of my face. I even need permission to scream.

Case Example #2

The second example is part of a transcript from a session between the author and a client who is called "Rhonda." The initial part of the therapy revolved around Rhonda telling her story. This brief interchange is from the third session and utilized to illustrate how to identify and access early developmental traumas (T = Therapist; C = Client). The presenting problem was distress over frequent migraine headaches. The T dialogue demonstrates reflecting back to the client. (Note: Cognitions that reflect possible prenatal and perinatal themes are underlined. The italicized words are clues to the long-standing nature of the problem.)

C: I've had a couple of migraines *every week of my life* I think. I've always been fighting them. It's hard.

T: You've always been fighting hard. Is there an emotion that's attached to "fighting" or "it's hard?"

C: Heartbreak, I think.

T: Heartbreak.

C: I had the same feeling in a dream. Sad, I mean, or something. I dreamed I was sticking really sharp objects into my eyes, you know? I think it means I don't want to see something. I was standing off to the side looking at myself, thinking, "If I do this I'll die, but if I don't do this I'll die too." That's a sad place to be.

T: Yes, very sad.

C: And yet one time last week when I was getting a migraine, instead of fighting it I tried like we talked about last time...to get into it, you know, not avoid it. And I thought, well, I'm just going to wait a bit before I get my migraine pills. I'm going to just...be with it, be in it.

T: Good for you. And what happened?

C: By the afternoon I realized that I didn't have it anymore. Maybe if I accept it, then maybe I take the pressure off of myself or something. Whereas, normally, my God, I'd think I was going to die. So that was real interesting.

T: Um-hum.

C: And when we talked about doing that last time? Like I left here thinking, "there's no way in hell, no way in hell that's going to work." But okay, I'll just see. But, I was

saying...damn, what happened to that migraine? I was going to have a bad day but it just went away. Usually with migraines, the pain is bothersome enough and I know I still have to function that I...it just...it just tones me down three or four notches, I don't have the energy to have a good day. That's the way it's *always been*. And now, it went away and I wasn't even thinking I was having a good day, and I was having a good day.

T: *Always been?*

C: Like that time? There was something going on at work that I didn't have any control over. And the boss blamed me for it and said I'm not doing a good job. It makes me feel so sad, but I'm also angry too, and I feel betrayed, horrible betrayed.

T: Horrible betrayed?

C: Yes, and then I think all I can do is wait...wait for something bad to happen. Like I'm going to die. To this day I hate to wait for anything. I think, people just don't appreciate what I do, you know? That's when I get really low sometimes. I just think, "nobody cares" you know? So why should I. I always break into tears when I think like this too. (pause/tears) I had a thought just now...I think my migraines keep me from feeling these bad feelings. And as long as there's something I can try to do, like take pills or take a nap or so, there's something I can keep working on to fix them.

T: Good insight. Sounds like you can regain control that way.

C: Yeah, God. How many times have I done that pattern over and over, I'll guess millions of times [client smiles].

T: Which is the better way to gain control over your migraines do you think?

C: Going with it instead of fighting it...that feels better too. Truer, do you know what I mean?

T: Yes. Any thoughts on the dream?

C: Yeah, well, I think now that there's nothing really that bad in there that I don't want to see. I hope that's true.

Based on this transcript, Rhonda's birth history could be hypothesized as one where she was likely stuck in the birth canal with her head painfully lodged against her mother's pelvis, consciously dealing with the fact that no one was helping her and that she might die. This material being too painful and overwhelming, stayed out of consciousness since the original event with the exception of the regular migraines. These appeared to be triggered by any situation where Rhonda felt out of control, and, like she concluded on the day she was born, she need to fight (hard) to live and seek ways to remain in control at all times. Interventions would focus on Rhonda's (being willing to) re-experience or regain consciousness around the stuck place, the hopelessness, the sadness, anger and the last chance at control, and her possible suicidal feelings.

SUMMARY AND CONCLUSIONS

The goal of this article was to touch on the prominent developments within prenatal and perinatal psychotherapy with adults and integrate them into a coherent, and practical guide for doing this kind of deep therapeutic work. Yet it is important to say at this point, as in the beginning, that prenatal and perinatal psychotherapy has not been rigorously tested. This article was written with the intention of beginning to fill that gap with future articles offered that describe the results of the use of this treatment model empirically.

Recommendations for designing a method to test this model could be either qualitative

(descriptions and analyses of clients' lived experiences) or quantitative (pre- and post tests, or more complex designs using factor analyses, or multiple regression based on identified independent and dependent variables.

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APPENDIX

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INFORMED CONSENT FOR INCLUDING EARLY DEVELOPMENT MODALITIES

I find that during the earliest of human developmental periods (prenatal and birth), experiences have a profound impact on later health and human behavior. Life is a continuum that starts, not as commonly thought, at birth, but at conception. The following is a brief summary of the validity of this developing modality.

- There is some empirical research that supports this construct.
- There are some significant gaps in the literature regarding this modality, as it would be at present be considered experimental. However, theoretically, pre- and perinatal psychology is firmly grounded in the well-accepted theories of developmental psychology, attachment, and trauma therapy.
- I have been studying and/or applying this modality for approximately 30 years.
- The **benefits** expected include a more thorough cessation of the symptoms you present with, *if they are likely to have begun during this period of your life*. The **risks** might be an increased level of discomfort as deeply held emotions are uncovered. You have the right to ask questions about any of the procedures used in the course of your therapy and I will explain my approach and methods to you. You have the right to not choose to receive therapy from me and in this situation I will provide you with names of other qualified professional therapists.
- This modality may include touch in support of healing. Permission for touch will be discussed in advance and only utilized upon your consent.

I will provide you with literature that will inform you about this modality, before and during the therapeutic contract.

“Under these conditions, I am willing to include the modality of prenatal and perinatal (birth) psychology as part of my therapeutic contract.”

Signature of client/patient

Date

Signature of Dr. Lyman

Date

Name of client (printed)