

The First Relationship

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Abstract: In this contribution the intra-uterine life will be considered from a psychological perspective and described as a 'first relationship'. It is embedded in the motivations, wishes and expectations of the parents and the culture, as well as in the vegetative resonance offered by the maternal environment (positive or negative). The prenatal child takes part in this relation dynamic and learns from it. Basic bonding patterns get deeply stored in the developing organism and especially the brain. The relation with the mother is a vegetative-organismic one and cannot be described alone in a Me-You-terminology. We see the prenatal relationship as a 'bonding' and name the particularities: the contact via chemical-emotional exchange processes, the importance of touch, sound and vibration, conscious and unconscious communication, as well as the (mutual) dependence. The psychotherapeutic approach of Psychodynamic Bodytherapy follows these characteristics and postulates that prenatal psychopathology is based on bonding deficits in the area of containment, safety, continuity and space. The last part of this article deals with the most important treatment principles of prenatal bonding deficits. Essential is the resonating relationship with the therapist.

Zusammenfassung: *Die erste Beziehung.* Die Lebenszeit in der Gebärmutter wird in diesem Beitrag aus einer psychologischen Perspektive betrachtet und als „erste Beziehung“ beschrieben. Sie ist eingebettet in die Motivationen, Wünsche und Erwartungen der Eltern und der Kultur sowie in die vegetative Resonanz, die die gebärmütterliche Umgebung zu geben in der Lage ist. Das pränatale Kind nimmt an dieser Beziehungsdynamik teil und lernt daraus. Grundlegende Bindungsmuster werden tief in dem sich entwickelnden Organismus, insbesondere im Gehirn, gespeichert. Dabei ist die Beziehung zur Mutter eine vegetativ-organismische und kann nicht einfach in Ich-Du-Begrifflichkeiten verstanden werden. Wir sehen die pränatale Beziehung als eine ‚Bindungsbeziehung‘ an und benennen ihre Besonderheiten: Der Kontakt über chemisch-emotionale Austauschprozesse, die Bedeutung von Berührung, Laute und Schwingungen, bewußte und unbewußte Kommunikation sowie die (wechselseitige) Abhängigkeit werden erörtert. Der psychotherapeutische Ansatz der Tiefenpsychologischen Körpertherapie knüpft an diesen Charakteristiken an und postuliert, daß eine pränatale Psychopathologie auf Bindungsdefiziten in den Bereichen Halt (Containment), Sicherheit, Kontinuität und Raum beruht. Im letzten Teil werden wichtige Prinzipien der Arbeit mit pränatalen Bindungsdefiziten dargestellt. Die resonanzgebende Beziehung des Therapeuten steht dabei im Mittelpunkt.

About 15 years ago my husband and colleague Hans Krens has started to include the prenatal experience into Psychodynamic Bodytherapy. His creativity and his deep understanding of vegetative, emotional and group-dynamic processes have always encouraged me to face these issues in myself and have immensely stimulated and enriched my theoretical and practical work. Therefore I want to dedicate this article to him with love and gratitude.

Inge Krens

Introduction

Since the baby watchers have discovered the ‘competent’ baby and its attachment needs, we know that the early relationship with the mother is crucial for the development of the personality and a possible source of future pathology. Considering the many indications from clinical experience and scientific research (see van den Bergh, 2000), though, there is reason to assume that life even before birth may contribute to the impact of the mother-child relationship.

The following considerations will try to explore these ideas. The background is the clinical field. From a scientific and academic point of view the concepts described here are quite ‘speculative’ in nature. Due to methodological problems, scientific research in this area is difficult. Nevertheless, our experiences may be valuable for the process of creating hypotheses to be scrutinised in the future. Our point of view derives from Psychodynamic Bodytherapy, a method developed by the Dutch psychotherapist Hans Krens. The approach bases itself theoretically and practically on a unique combination of psychodynamic thinking, attachment theory, prenatal psychology and body-psychotherapy. In the 15 years of experience in this area body-psychotherapeutic methods of working with prenatal bonding deficits have been developed.

Relationship in the Womb?

The term ‘relationship’ defines a unique and ever changing dynamic between at least two organisms, more or less dependent on, close to and/or attracted to each other. In order to function optimally, the organisms ought to be impermeable on the one hand, and relatively stable on the other. One can give different names to this dynamic: interaction (motoric), resonance (vibrational), exchange processes (chemical), answer (verbal), bonding (emotional), interdependence (social) etc. The relational dynamic affects both organisms.

Probably we have to consider that what is true for the human species is valid as well for prenatal life: Human beings need and influence each other. Their existence is interdependent. It is impossible not to be in ‘relationship with’ because when there is a human being there is an environment. In this sense it is defensible to suggest that it also applies for the different phases of the prenatal relationship. Maybe there is a relationship/interaction between the fertilized ovum and the fallopian tube as well as between the foetus birthing itself and the birth canal. It seems obvious that this relationship is characterized by dependence. Because of the permeability and vulnerability of the embryo/foetus the impact by the mater-

nal organism is evident. In some sense the prenatal child¹ ‘swims’ in a relational space and its physical and emotional development is unthinkable without it. As mentioned before, this means that the relational dynamic will change both organisms structurally. They learn from it and will never be the same as before. These learning experiences will influence the human being profoundly on all levels of his or her existence: on the capability to relate with him/herself and his/her body, with other human beings and on his or her attitude and feeling towards contact with the world and with life as a whole.

When Does ‘Relationship’ Begin?

We assume that this process starts with the qualitative aspects of conception. When else? When else would we consider the beginning of ‘relationship’? After birth? Maybe because we can then see the child and touch it and observe it? Because then it is easier to be researched by empirical studies? Does it start when there is a brain and a nervous system? Is relationship dependent on a functioning nervous system? Or does relationship start after 3 months of intrauterine life, when our laws forbid abortion? Or does relationship start after implantation at the age of about 1 week of intrauterine life? Or maybe after the differentiation of cells into endoderm, mesoderm and ectoderm, when the cell formations “become individual” as the experts on ethics say in order to justify research on stem cells?

In a way, the question about when ‘relationship’ begins resembles the question of when “life” begins. And this is not a coincidence. Where there is life there is relationship. It’s a basic principle of life. From conception onwards, the human genes interact with their environment (Deneke, 1999). The human species is known for its developmental potential and adaptation to the environment. It is designed to integrate the environment in order to control and influence it. The organism develops and takes shape due to constant interaction: on the one hand the growing layers of cells are being differentiated with and according to outside stimulation, genetic possibilities and its developmental stage. On the other hand, the developing human being is relatively autonomous in sending out certain signals to its environment, in order to influence it.

As mentioned before, a human being does not live in a vacuum. Human beings have to learn how to love, care, be aggressive, be sexual etc. Throughout life, the human brain is even producing new nerve cells so that all old and new experiences can be synthesised into unique individualised social communication patterns. Therefore the human brain is a never-ending learning organism dependent on the exchange processes with other human beings. There is no “Me” without a “You”. It is impossible not to be in ‘relationship with’: a human being can only survive in a social environment.

¹ The child of intra-uterine developmental phases is usually called ‘the unborn’. From our point of view this term reflects the denial of prenatal life: associations like ‘not yet there’ or ‘to take serious only after birth’ suggest themselves. Therefore we prefer the term: ‘prenatal child’.

Conceived into a Complex Ecology

But does ‘relationship’ start with conception? From a biological point of view this surely is the case. From a psychological and social perspective, however, the interactive relationship may start already with the thoughts the future parents have about the child, about wanting to have a child, or just not wanting to have a child; with the love and longing for it, the wishes, expectations, fears and hidden and unconscious motivations. From a systemic perspective we assume that the child is not conceived into a vacuum, but into a physical, emotional, social and spiritual ecology: Maybe the parents deeply want the child, maybe they need it to fill an emotional gap, to bind the partner to the relationship or to repair it, to fulfil a wish of their own parents or to compensate for achievements they were never able to make. Do these preliminary circumstances matter to the future relationship? Does it matter if the child is conceived out of love in an intimate and stable relationship, or out of the physical need for closeness, out of the feeling to emotionally need the partner desperately, out of sheer lust, carelessness, indifference, out of guilt, revenge, anger, maybe out of violence. Does it matter?

Many people would agree intuitively. We also assume that highly emotional events in pregnancy will not be experienced as ‘neutral’ by the involved. Nevertheless the consciousness about the importance of the prenatal period for the development of the child is still not widely spread. Even professionals working in daily contact with pregnant women like obstetricians and midwives seem to have learnt to deny it. In the therapeutic field, the same is true.

The Prenatal Threat

Sometimes the collective negligence of prenatal realms seem to be so absolute and irrational that from a psychological point of view we assume that cultural defence mechanisms may be at work.

This may have the following reasons:

- The deep-rooted notion supported by medical doctrines in western culture, that body and psyche are separate. If one believes that at prenatal stage all processes are purely physical, then it is easy to come to the conclusion that the beginning of psychological life commences only in the postnatal phase.
- Western societies demonstrate a widely spread fear of feminine qualities of life such as feeling (versus thinking), slowness (versus speed), dependence (versus independence), commitment (versus freedom to go), togetherness (versus individualism).
- The unconscious recollection² of prenatal experience may be felt as frightening. Prenatal experiences are part of our non-conscious vegetative adaptation

² The notion of memory as a storage model is obsolete. Memory is not linked to one organ. It is a functioning of the whole organism and involves a “complex, dynamic, re-categorising and interactive process.” (Leuzinger-Bohleber et al. in Koukou, 1998, p. 519) “In the field modern memory research . ‘Memory’ is defined as everything that reflects previous experiences. Such definition thus also includes pre-verbal, pre-representative, pre-symbolic, and indeed pre-natal experiences, which have, in more recent times, increasingly become an issue in psychotherapeutic work.” (Köhler in Koukou et al., 1998, p. 142)

and learning process. We hardly can access memories of this vital period of our lives through consciousness and if we try to think about them, this will normally be a blank screen. This seems to be frightening for the psyche (not to think). If this blank screen is also combined with frightening feelings, difficult to understand and to handle, it may be a good reason to deeply hide them away into the unconscious.

The background of this is that not every child is welcome: sometimes the life circumstances are difficult, there is economic insecurity, the relationship with the father is unsafe or absent or the woman is emotionally unable to accept the child. Unfortunately, we have to realise that life in the womb may not always be paradise. In many cases it is not the heavenly and blissful state often romantically described by some authors, where the child is protected and cared for by a loving mother. For some people it seems to resemble an experience of hell they have survived more than anything else. No wonder that they will do anything not to be confronted with these experiences.

Whether it's hell or paradise, it is a phase in life in which potential extremes can be experienced: Negative experiences can include death-anxiety and existential fear, loss of identity and being cut off from life. In positive circumstances the child can experience togetherness, interconnectedness, peace and the feeling of being one with itself and the world.

Who is Relating to Whom?

Obviously the pre-nate and its mother relate to each other. However, if we want to find out about the characteristics of the prenatal relationship, we should try to describe it more precisely. Actually, it is a special environment the pre-nate is living in. Think of the physical closeness of the womb with its very individual shape and consistency, the relative darkness there, the placenta and the umbilical cord as touchable objects, the intense blood connection between pre-nate and mother that connects their bodies and souls, the ebb and flow of the amniotic fluid, the permanent stimulation through movement and sound . . . The philosopher Peter Sloterdijk describes it as follows: “. . . the child-to-become (experiences) sensory presences of fluids, soft bodies and cave-boundaries . . . to start with the placental blood, then the amniotic fluid, the placenta, the umbilical cord, the amniotic sac and the vague notion of boundary-experiences through the resistance of the abdominal wall and the elastic coverage. If there were any early ‘objects’ in this field, they could only . . . be object-shadows or things-to-appear . . . As a candidate for these things-to-appear the first to consider is the umbilical cord – with possible early experiences of touch – as well as the placenta that represents the first ‘other’ and possesses an early diffuse presence as a nurturing ancient companion of the foetus.” (Sloterdijk, 1998, p. 299–300)

In this sense we would fail to recognise the characteristics of the prenatal relationship, if we reduce it to an “I-You”-relationship. Sloterdijk even suggests the following: “To avoid straying into object relation theory, we give the organ that the pre-subject communicates with while floating in its cave a pre-objectual name: we call it the WITH . . . If the name of the being was to be created anew, it would have to be called the ALSO; for the foetal self only results from the returning from

the state of WITH there to the here, the ALSO HERE . . . For a good reason, the WITH could also be named the WITH ME; for it accompanies me and me alone, like a nurturing shadow and an anonymous sibling . . . By being constantly faithfully and nurturingly close there, it gives me my first sense of my lasting HERE.” (Sloterdijk, 1998, p. 360)

This way of looking at the prenatal relationship is illuminating and may help to leave the academic considerations and enter a feeling contact with what the pre-nate may experience. It's about floating and gliding down the fallopian tube, about flowing and being flown in the waters, about whirling, shaking and rocking with the movement, about rubbing, kneading and crushing before birth; it's about sensing and feeling, about swimming in resonance, about life and death, about the bliss to feel one, loved and wanted and the terror of being aborted. It's about the longing for oneself through the other.

This means that in speaking of the prenatal relationship between mother and pre-nate, we have to be aware that we are looking at very different aspects of the “mother-object”: She may be represented by the egg cell, the ovary, the fallopian tube, the placenta, the amniotic fluid, the umbilical cord, the womb, the birth canal or the vagina. The pre-nate interacts with all of them at different stages in its development.

To make it even more complicated: The prenatal child shows itself in very different shapes too: as a fertilized egg, a morula, a blastocyst, an embryo or a foetus. It is obvious that there are huge developmental differences between a fertilised egg, an embryo and a foetus ready to be born, not only physically but also in terms of the possibilities and ways of perception and relational capacities. This means that the prenatal relationship is greatly differentiated. To contact it in its complexity means to let one enter into a unique and inter-subjective feeling world. It's not something that can be handled only intellectually.

As Psychodynamic Bodytherapists we postulate that the prenatal relationship does not stop at ‘mother’ and ‘pre-nate’. Especially the inter-relationship with the father does have an enormous impact on this dyad. Studying over 1300 children and their families, Stott (in Maret, 1997, p. 74) estimated “that a woman trapped by a stormy marriage with an abusive or unsupportive husband runs a 237% greater risk of bearing a emotionally or physically handicapped child as opposed to a women from a secure, nurturing stable marital environment.” The father belongs to the ecology of the child. His way of reacting to the pregnancy, to the changed relationship with the woman and the level of support and stability in emotional and economic terms he is able to create will generally be of great influence on the stress-level the woman has to face in her pregnancy. Besides this, the father is obviously present through his genes. We suggest that these are the ingredients and the environment that creates the basis of a “we”-relationship, which may be the emotional foundation of what much later differentiates into a triangular relationship.

The Prenatal Relationship as the First Bonding

The term “relationship” is very vague, describing any dynamic between two objects. It is used colloquially to describe your relationship with your neighbour as

well as with your collection of stamps. Acknowledging the special features of the prenatal relationship we have reason to think of it as an attachment or bonding rather than a “relationship”.

The concept of “attachment” refers to the findings of the attachment theory described by John Bowlby and many others. It refers to a special kind of relationship:

- A relationship that is based on intersubjective human needs. It has the quality to ensure survival.
- A relationship that includes emotional involvement and continuity.
- A parent-child-relationship that supports developmental growth in a “good enough” way. The sensitivity of the parents with regard to the child’s basic needs is a precondition for it.
- The relationship’s characteristics are experienced and memorized by the child physically, emotionally, cognitively and behaviourally. Attachment representations will be formed that colour future relationships.

We believe that all these categories are valid for the prenatal period: Prenatal attachment is very likely to have a biological base. Only an organism that is able to recognise some aspects of the totally new environment after birth is able to survive (Hepper, 2001). Evolution provided the foetus with the ability to learn and to attach to its mother in order to recognise her after birth. Furthermore the pre-nate seems to have not only physical but also emotional needs that have to be met “well enough”. The postnatal “sensitivity” of the mother therefore has to be translated into a prenatal “organismic resonance”: a maternal organism resonating with the changing needs of the pre-nate: e.g. providing the right nutrition, enough space to move, a womb that is flexible enough to be able to contract and expand, hormones through the umbilical cord that are “friendly” enough and thoughts and ideas that are warm enough to keep the stress level of the pre-nate in limits. Furthermore there are indications from scientific research and clinical practice that the characteristics of this first relationship as organismic imprints into the implicate-procedural memory³ may be ‘memorised’ as physical, behavioural, emotional and cognitive patterns that may have an impact on the further interaction patterns of the child and even the adult.

Therefore we do suggest that a broader definition of “attachment”, including the prenatal period, may be justified and important. We are aware though, that the classical attachment theory clearly refers to the postnatal period.⁴ Moreover

³ “The implicit memory system does not only include sensory perceptions, but also motoric and behavioural patterns together with simultaneously experienced emotions . . . for the psychoanalyst it is important that early acquired expectations and behavioural strategies, as for example described within the field of bonding research, are adopted into the implicit memory. They are not consciously accessible and are only expressed through behaviour. Also early experienced emotional patterns are initially stored in the implicit-procedural memory and form the so-called ‘emotional nucleus’. (Köhler in Koukou et al. 1998, p. 144)

⁴ A few attachment theory oriented studies include the pregnancy. (Fonagy et al. 1991; Benoit and Parker, 1994) E.g. Fonagy et al. focused their research on the attachment representations of the woman during pregnancy and compared it with the attachment style

its research methods are not transferable to the prenatal relationship. In order to pay tribute to the scope of this theory we will in the following avoid the term “attachment” and use “bonding” instead.

Characteristics of the Prenatal Bonding

1. The Emotional Quality of the Bonding Is Mediated Through the Exchange Processes of the Umbilical Cord,

which connect the two organisms with each other via the blood which connect the two organisms with each other via the blood circulation. “It drinks with her, smokes with her, loves with her and hates with her, enjoys with her and suffers with her. It feels the heartbeat of the mother, it is scared when she is, it worries about her since it cannot live without her. Its life depends on her and her life.” (Fedor-Freybergh, according to Janus and Häsing, 1994) Harmful substances like nicotine, coffee, alcohol or other drugs invade the foetal organism almost unfiltered. But emotional states also have a direct effect through hormonal changes in the blood, through the quality of the oxygen supply and the changes of the heart rate. This is because emotional states go together with “affect-appropriate physiological changes of the endocrine system and the autonomic nervous system, directed by the hypothalamus”. (Maret, 1997, p. 73) When the mother feels anxious or fearful, “various hormones, including adrenaline, flood into the blood stream and easily cross the placental barrier, thus provoking, biochemically, the physiological reaction to anxiety and fear in the foetus”. (Maret, 1997, p.73) If a certain limit is not respected in this process, i.e. levels are below or above, the organism experiences this as life threatening and reacts with the typical survival strategies of ‘fight, flight or freeze’. These reaction patterns are also shown by foetuses as proven in ultrasound treatment.

We can conclude that the experiences the child makes with the maternal environment are very organismic in nature, a term that is supposed to describe the complex interplay of physical and emotional aspects.

2. The Emotional Aspect of the Prenatal Bonding Is Mediated Through Tactile Contact

The child touches and is touched by its environment: the uterine walls, the amniotic fluid, the placenta and umbilical cord. The quality of the ‘contact objects’ may be extremely variable: The uterine walls for example may be chronically contracted, loose or flexible. They may be sensed as warm and responding or hard and cold. There even may be mechanical impact from outside, e.g. when a woman forces her belly in corsetry to conceal her pregnancy. Tactile contact can also be given directly by the mother: a soothing hand on the belly is a gesture pregnant women all over the world are conducting in order to contact their child. Through touch the pre-nate is sensing the world around him. It learns what it feels like to

between her and her child at the age of one year. The correlation between the data indicates an intergenerational transmission of attachment styles, but does not say anything about the way this transmission is actually happening. There is no suggestion that it is mediated by the prenatal bonding relationship.

be “in the world”: Hard or flabby, cold or warm, hostile or friendly. With its own movements the prenat can contact its world. It can move spontaneously already with about 8 weeks. Through its movements it can communicate its condition via touch. For example, we know from prenatal stress research that one typical foetal reaction pattern to maternal stress is hyperactivity.

3. The Prenatal Attachment Is Mediated Through Sound and Vibration

The morphological structure which would allow hearing to occur are present and functional in the prenat from 20 weeks on (Eisenberg in Maret, 1997, p. 57) The vestibular nervous system is functional at the end of the 4th month already. The ear is the only sensory organ that is fully functional before birth. (Tomatis, 1999, p. 104) This may refer to the possible relevance of the auditory perception in utero. Research shows that foetal listening, as measured by response to sound, is quite constant from the 24th week on. (Maret, 1997, p. 58) Alfred Tomatis, (the founder of the ‘electronic ear’), who has extensively studied the hearing process in utero, comes to interesting conclusions: the prenat does not need a functioning ear to be able to ‘hear’ sounds. “The ear, due to one of its parts, the vestibulum, is able to perceive rhythms from the first weeks of intrauterine life.” (Tomatis, 1999, p. 10) Sounds are transferred by oscillation. He found that the sounds entering the mother’s body are transferred to the pelvis via the bone structure (esp. the spine). Acting like a sounding board, the pelvis begins to resonate at between 2.500 and 3.000 Hertz; the frequency of a female voice. It is the higher frequencies the prenat is able to hear. Just right to concentrate on mother’s voice. “What the foets hears best, is the mother’s voice since the auditive bandwidth of it that gets through to it, corresponds precisely to its audioperceptive abilities. Does it understand what she says? No. It only knows the emotional side. The decoding it performs is non-semantic. It is nothing to do with the content of the message. It does not need this dimension for its world is exclusively affective.” (Tomatis, 1999, p. 71) Tomatis is convinced that it is only the mother’s voice that the prenat hears. All other sounds are mediated through her hearing and the corresponding resonances. The importance of the mother’s voice is proven by infant research: newborn babies are able to recognise the voice of their mother. It is obvious that this supports the survival of the child. In this sense the “psychoacoustic initiation of the foetus into the sonic world of the mother’s body” (Sloterdijk, 1998, p. 302) may contribute to prenatal bonding.

4. The Prenatal Bonding Is Mediated Through Conscious and Unconscious Communication

The biochemical explanations for the influences of the maternal emotional reactions on the foetus are interesting but the question still is whether these explanations are sufficient to describe the complex dynamics between mother and child. E.g.: How is a feeling like ‘love’ “transferred” to the child? What are the decisive factors – hormones, breathing patterns or heart rate? By caressing her belly, by eating good food, by warmly thinking of the child? All these descriptions are true but they lack the complexity to explain the feeling contact between mother and child. (See Verny, 1993, p.71) Frank Lake was aware of this and described these

phenomena as telepathic communication. From our clinical experience we can confirm the idea that there must be a communication system beyond those that are purely neurologically measurable. We do not know how it works but it seems to occur between people with a close and strong feeling contact. This obviously is a fact for the prenatal relationship. Raffai states that this rapport is only possible when an "attachment space" has been built.

To summarise, we assume that there is a channel of communication between mother and pre-nate that transmits not only the physical but also the emotional state of both. This type of communication seems to be one of the main modes of contact during the prenatal period. It seems that pregnancy stimulates the unconscious perception. Everybody knows numerous examples of mothers intuitively "knowing" the sex of the foetus or feeling if something is wrong. Some therapies, like the mother-foetus-bonding analysis by the Hungarian analyst Jenő Raffai, use this channel to contact the pre-nate and to 'talk to it'. He describes the case of a pre-nate who has not turned upside down before the birth. The mother realises that she herself has been a breech delivery and tells the child that it does not have to repeat her own history. The following night the child changes its position. (Raffai, 1999, p.361)

This example suggests the intensity of the communication between mother and child. We have to consider a strong unconscious quality of this communication. This can be for the better or for the worse. Verny explains that about one third of all spontaneous premature births occur for no medical reasons. (Verny, 1993, p. 78) He assumes that for outer and inner reasons the mother unconsciously communicates to the child that it has to leave the womb. Or the child "decides" to go because of a stressful environment. This is not because the woman is a bad mother, but because there may be life situations and inner conflicts too heavy for her to handle. The hypothesis though is, that the two organisms are interacting in an unconscious communication process. In this case a negative one, one that may lead to a premature birth.

There obviously may be various reasons for that including very stressful life circumstances. (Situational factors like severe disease, death of a loved one, insecure economic situation, exposure to chemical or environmental poisonous substances, a heavy work load) there also may be relational factors like conflicts in the relationship with the father of the child. Mostly though these outer stress factors are experienced as negative even more if accompanied by a weak emotional state or structure of the mother. Normal anxieties during pregnancy are reinforced and unconscious emotional conflicts are increasingly part of the communication with the pre-nate. The mother will tend to project these conflicts unconsciously on her child.

Furthermore we assume that many emotional conflicts of the pregnant woman derive from the inner confrontation with her own prenatal experiences. This also may include a confrontation with the inner representation of her own mother's (womb). Sometimes this means a confrontation with existential issues: then it is about feelings of life or death, about feeling helpless and needy without anyone there, feeling annihilated or destroyed, feeling used and caught in the web of the spider and threatened to be eaten up, the feeling to be tortured. These may be

extreme examples but they do illustrate the inner turmoil there is for some women when being pregnant.

Raffai illustrates the possible drama of this for the development of the child: "... the mother is especially connected to her child via her unconscious. This means that the psychopathology of the mother will be projected onto the child and will appear as its own in later development". (Raffai, 1999, p. 357)

We conclude that the prenatal bonding relationship can be influenced positively as well as negatively by the quality of the maternal (and paternal) consciousness on the one hand, and the quality of unconscious communication patterns on the other.

5. The Prenatal Relationship as a Unitive Bond or the Longing for Oneself through the Other

As mentioned before it seems inadequate to look at the prenatal relationship as an I-You relationship,⁵ because this concept is not able to describe 'Co-Subjectivity' (Sloterdijk, 1998, p. 571). The historian Barbara Duden criticises the tendency to speak about the foetus almost without realising that it is only there because a woman is carrying it in her body. The mother's uterus is degraded to be a "potential systemic environment for an immune system to nest in". (Duden, 1991, p. 57). Sometimes the mother is seen to be the 'threatening environment', the foetus has to be protected from. The pre-nate is no longer an "experience in its mother's belly". (Duden, 1991, p. 95). Now, via ultrasound, it can even be looked at. It is "made public" as though it existed outside of its mother. I think we should take Barbara Duden's warnings very seriously. We have to consider that, modifying Winnicott's famous remark: 'There is no pre-nate without a mother.' We extend it by saying: 'and without a father and a society'.

However, this is not to mean that the emotional relationship between mother and pre-nate is to be characterised as a fusion with no difference between mother and child. From our clinical practice we come to the conclusion that the prenatal relationship is not to be characterised as a complete fusion nor as an individuated I-You relationship. When we work with adults on their prenatal experiences, we realise that somewhere deep down there seems to be an awareness of a feeling of oneself – a core-self – long before it becomes manifest in behaviour, feeling and identity. Marshall Klaus and others suggest that when they mention that "perceiving the foetus as a separate individual" is one of the events "important to the formation of the parent-infant-bond" (Klaus, Klaus and Kennell, 1995, p. XXV). This means that experiencing the child as close and connected but different actually is one of the preconditions of healthy bonding processes.

We characterise the prenatal relationship as a "unitive bond" (Krens, 1999, p. 12). This means that the bonding experience in this phase of life strives towards a confirmation to be "one with oneself" and at the same time "one with the other". It is about existence through co-subjectivity (Sloterdijk, 1998, p. 571): Longing

⁵ "It is known that the ethics of psychoanalysis have their roots in the Jewish conception of law. They do not support fusions but unremittingly plea for constructive separations; their focus is not the intimate fusion, but the discretion of the subject in the face of the other." (Sloterdijk, 1998, p. 221)

for oneself through the other. It is the place where the soul “as a field of interpersonal resonances” (Sloterdijk, 1998, p. 243) starts to get shaped. In this sense the prenatal learning experience, (obviously translated into adult wording), could be characterized as including interdependent as well as ‘autonomous’ sides: ‘All being connected to all’. Thus it represents the most basic characteristic of human existence. This can only be achieved if the mother is able to make herself available as a container and a sounding board for the child’s being.

6. The Prenatal Relationship Is Characterised by (Mutual) Dependence

It is quite obvious that the prenatal relationship is characterised by dependence. The life of the prenaté is dependent on the nourishment, the shelter and the emotional resonance of the mother. The prenaté does contribute to the relationship, though. It does influence the relationship through hormones (from the placenta which actually is an organ created from its own cells), its organismic state, and its movements. In this way we truly can speak of interdependence between mother and prenaté. But in terms of the consequences of this relationship there is obviously quite a difference between them. The prenaté is busy building its body and especially its brain. The brain development is very sensitive to modulation. Intra-uterine experiences “wire” the brain. The prenatal dependence shows itself in the fact that the prenaté is learning from its experiences from the beginning. It is learning from positive experiences preparing it for a world that feels friendly and warm. It is also learning from negative experiences preparing it for a world that may feel like a hostile and dangerous place.

7. High and Continuous Stress Levels in the Prenatal Relationship may Lead to Trauma and Shock

Connected to the issue of dependence is the fact that the prenaté has very limited possibilities to protect itself from negative stimuli. In ultra sound one can see that the prenaté starts to move more when in a stressful situation. It seems to try to fight the uncomfortable situation. If the stressful situation goes on it tends to stop the movement and “freeze”, as if to contract in anguish. With high and continuous stress levels the problem gets worse: because quite literally, ‘there is no way out’. Frank Lake described this situation as producing “transmarginal stress.” (Lake, 1998, p. 23) It leads to the feeling that there is no way to handle the situation. Clients reported in such situations that all they wanted was to die. Death was felt as the ultimate solution. William Emerson, one of the pioneers of prenatal psychotherapy, describes the consequences of distressing life experiences as ‘shock’. Shock is even worse than trauma. “Shock refers to negative and distressing life experiences that are overwhelmingly painful, cannot be coped with and which powerfully affect the physiology and psychology of the victim . . . there is little or no choice or power . . . When shock is activated, the whole shock system and all unresolved shocks are simultaneously activated, whether they are thematically related or not. This means that if one shock is restimulated . . . the entire shock system is also activated, together and at the same time. Activation occurs at unconscious levels, so that clients are not aware of simultaneous shock memories: they are only aware of distress, of dysfunctional feeling or behaviors,

or of memory fragments” (Emerson, 1999, p.1) Because of the weakness of their defence system prenatates are susceptible to shock. (Emerson, 1999, p. 2)

The following conclusions seem important in terms of the treatment of pre-natal shock:

- Prenatal shock will weaken the ego-to-become and therefore heightens the possibility for further traumatic experiences later in life.
- Multiple trauma may also be linked to a compulsive tendency to repeat early distressing relationships later in life
- In dealing with multiple trauma in clients it is worthwhile to consider prenatal trauma.
- When diagnosing, the therapist should be aware that reasons of prenatal shock are deeply unconscious. They show themselves, similar to symptoms of post-traumatic stress disorder in intrusions, dreams, physical numbness, dissociations, fight/flight impulses in view of feelings of love, shame and dependence etc.

7. Prenatal Psychopathology and Prenatal Needs

Prenatal psychopathology is the result of a lack of resonance or a negative (inadequate) resonance from the maternal organism to the physical and emotional needs of the prenatate. In this sense we think of prenatal psychopathology as bonding deficits. In this definition we even include ‘physical’ events like a temporary lack of oxygen or food supply. Since it probably is impossible for the foetus to differentiate between physical and emotional processes and their motivations, we assume that ‘physical’ events may be experienced as an emotional interruption of a bonding continuum, too.

Aspects of Prenatal Bonding Deficits and Prenatal Needs

General: The Need to Bond and to Receive Adequate Resonance

The basic emotional need of the prenatate is to be allowed to bond to its mother in a positive way. Precondition for that is her adequate resonance towards its needs. Different aspects of the same basic need may be involved:

The Need to Be Contained Versus the Threat to Dissolve/to Disintegrate

The anxiety to lose the boundaries and to disintegrate is felt as a real danger in some very early-disturbed clients. From our point of view psychotic disintegration is the last means for the organism to “handle” severe death-anxiety from prenatal bonding deficits. This death-anxiety takes over in situations felt as existentially threatening when there is no memory of a resonating container available.

In a positive sense, the resonating womb serves as a container. The container gives shape and protection, it is an environment that is there to be used unconditionally. It enables the prenatate to concentrate on him/herself. In this sense the development of boundaries and the ego-structure starts in the womb.

The Need to Be Safe in One's Existence Versus the Threat of Being Destroyed

Prenatal bonding deficits manifest themselves in some clients as existential issues: Emotionally, life or death is at stake. This may go back to planned or carried out abortion attempts or other forms of near death experience.

The threat of destruction of his/her existence is part of the life of these clients. Sometimes this even becomes real: Some clients chronically engage themselves in situations that involve existential issues of life or death. A history of attempted suicides is common. Another symptom is the tendency to "abort oneself". (see Janus, 2000, p. 141) It is interesting to note that this behaviour typically is presented in situations that involve enough security and in which positive bonding experiences are actually possible. That means that the person acts to destroy potentially "good" situations of relationships in order to hang on to the past experience.

The Need to Be Connected Versus the Threat of Being Expelled

Some bonding deficits may result in the feeling not to be wanted. The mother may feel cold towards the child and distracts all her attention away from him. She does not fight it actively (like described in the paragraph before), but is not available emotionally. Her reaction may have reasons due to the psychopathology of the mother. On the other hand stressful life situations may contribute it it: Think of a conception by rape or by other circumstances involving social shame and disgrace, domestic and social violence, serious financial crisis or divorce. (Emerson, 1999, p. 3)

In reaction to the situation the prenatal child is most likely to avoid attracting attention to it and withdraws emotionally. This is possibly linked to a feeling of existential loneliness, helplessness and a deep-rooted sense of being lost. Being banished and excluded from human contact contradicts the inner necessity, 'to be included' and 'a part of humanity'. Compensation attempts in the form of adaptation, psychosomatic splitting and/or narcissistic retreat (see Janus, 2000, p. 149) to a maybe magnificent, yet in the end lonesome and bondless world, keep up the (neurotic) bonding to the emotionally not available mother. However, in the long run these compensations are not tenable. Eventually they will lead to existential crisis, expressing the deep-rooted sorrow for a denied happiness of life.

These etiological views remind us of the syndrom of the 'Dead Mother', described by André Green (Green, 1983). Green describes the consequences of an abrupt break-off of a contact intense relationship between the (postnatal) child and its mother.⁶ The trauma for the child is disruption and a threatening loss of inner continuity, the alienation from the organismic self, and the retreat into bondlessness. The child tries to compensate this loss by adapting to the needs of the mother, yet remains linked to the 'dead' parts of the mother and cannot escape inner 'white sorrow' (Green, 1983). Although Greens theory does not deal with

⁶ "The first and most important (mechanism) is a single movement in two directions at the same time: the engagement withdrawal from the mother 'object' and the unconscious identification with the dead mother. The taking back of mainly the affective engagement, but also the engagement withdrawal of the imagination are a psychological murder of the 'object', executed without hate." (Green, 1993, p. 215)

the pre-birth situation at all, we regard his thought as very inspiring. His ideas fit to some of our experience with people, who have the feeling of being “unwanted”, yet love the traumatising mother and hold on to the internalisation.

The Need for Space Versus the Threat of Being Invaded

Bonding deficits may show in the experience of a violation of one's organismic boundaries. The need to be respected as different from the mother has not been confirmed enough. The mother experiences the child in her belly as a part of herself, without consciousness of it being a separate person already. There is – sometimes literally – no space for the child. These clients had mothers who needed the child for their own emotional balance. Their neediness and lability, increased by the pregnancy, wake up her wishes for her own (womb-) mother. She projects them unto her developing child, who is supposed to satisfy them. In this sense the pre-nate is used instead of the pre-nate using the maternal environment for its own development. To protect itself the child reacts by reducing its spontaneous movements and slowly identifies with its ‘role’: It feels as if it only can ‘be’ if it is there for somebody else. Compensatory strategies may be expressed in two different ways: the person identifies with being the victim, which could result in a person with little contact with itself, its aggression or identity, who lets itself be used by other people and functions for others, rather than living its own life. Alternatively, the person tries to resist the threat of violation of its boundaries by identifying with the ‘aggressor’. These clients close up towards feelings and needs of others and possibly have a tendency to – mostly hidden – emotional violence.

Summary

The above outlined aspects of prenatal bonding deficits as well as the etiological notions are first attempts to describe disruption susceptibility in prenatal relation dynamics taken from our clinical experiences. We believe that the four outlined needs for support, security, continuity and space are vital emotional foundations in prenatal existence.⁷

In describing these aspects it was consciously avoided to link them explicitly to pathology examples (although some would immediately spring to mind). We want to take care not to succumb to ‘classifications’ and a premature diagnosis. Humans are complex beings with complex experiences. Our attempt to structurally describe bonding experiences serves the purpose to shed some light on the jungle of these complexities, without losing sight of its multi-layered characteristics. This approach also goes hand in hand with our work, as it may become evident below.

However, we would like to mention that there are very interesting contributions to this topic by authors who ventured into detailed descriptions of emotional symptomatic in relation to particular stages in prenatal development. The Spanish

⁷ However, we do not think that they were described in all details. For example we haven't taken into consideration contributions exploring prenatal development in relation to sexual identity. This is due to a current lack of clinical experiences.

body-psychotherapist Marc Costa Segui assigns particular symptoms in different stages of embryonic development and postulates intra-uterine roots for character structures. He describes, for example, symptoms relating to the right to exist as 'schizoid experiences', which are associated with very early emotional violation in the first few weeks of life. (Costa Segui, 1995, p. 315/316) David Boadella establishes a connection between character structure and prenatal development in relation to the schizoid and hysteric symptomatic. "Many schizoid symptoms indicate the need to regress inside mother's belly, to be inside the capsule, and return to the dream-life of the womb. On the contrary, the hysteric character is in flight of the mother's belly . . . (he) continuously searches for escape routes, in order to achieve an explosive release of tensions in the head and translate them into physical symptoms." (Boadella, 1998, p. 78)

Generally speaking, we have reason to assume that the roots of most pathology, surely of the more severe, can be traced back to the prenatal realms. This does not mean that symptoms always have to be traced back to the earliest beginning in therapeutic work, nor does it mean that postnatal experiences are irrelevant. But we do assume that the predisposition of the personality including the formation of the ego-structure has been developed already. Moreover for many people the experiences they make after birth may be much the same as the ones before birth. So the patterns grow more and more manifest.

On the other hand the possibility to compensate negative experiences by means of positive ones is a fact. We know that the organism has an immense urge to heal itself and will take any opportunity to 'work through' negative experiences. The stimulation of this intrinsic potential is the basis of our therapeutic work.

Body-Psychotherapeutic Work with Prenatal Issues

Basic Principles

In the following I want to describe shortly some principles when working with prenatal issues. Stimulated by Hans Krens Psychodynamic Bodytherapists have developed them over a period of about fifteen years. We cannot go into detail here, but we hope to illustrate some of the basic issues one encounters when working on prenatal traumatization.

The Key Element of Prenatal Traumatization Is a Severe Bonding Deficit

As mentioned before we base our work on the assumption that the key-element of prenatal traumatization is a severe bonding deficit. This means that in the treatment process the relationship with the therapist is of utmost importance. To have healing quality the characteristics of this relationship should resemble those of the prenatal one:

- *Physical and emotional at the same time – the organismic relationship:* The relationship is of organismic quality, including emotional and physical features. The quality of the relationship is not limited to emotional and psychological resonance but can be experienced physically by touch.
- *Resonance:* The healing quality of the relationship is based on organismic resonance. The sounding board of this resonance is the organism of the therapist.

It can be transmitted by touch, rhythm and sound. Body-contact work is the most direct way to let the client's body experience organismic resonance.

- *The safe container*: Symbolically the therapist partly takes on the role of the 'womb' that resonates in a good enough way, let itself be used 'like water and air' (see Balint, 1997) and provides continuous and secure supporting environment.
- *Dependence*: Feelings of dependence from the client to the therapist will be an issue one has to deal with. It is important for the therapist to understand them as part of the psyche's opening up process and he must work through them in a respectful way.
- *To be 'personal'*: The therapist has to feel ready to open up to the client with his or her whole being. A technical or neutral relationship is not adequate when working on prenatal levels.
- *Bonding*: The therapist has to be ready to bond and to allow the client to bond with him/her.
- *Positivation*: Therapist and client encounter each other in a complex world of feeling, sensing, touching and moving. As a therapist one has to dare exploring frightening worlds and hold on to the unshakeable belief that as long as there is life there is also hope.

The following text describes some of the basic principles of the work on prenatal bonding deficits in more detail:

The healing quality of the relationship is based on organismic resonance. If there is a necessity for "relationship" in psychotherapy, then it surely is in working on prenatal bonding deficits. The client urgently needs the personal presence of the therapist. This personal presence shows itself in her ability to resonate with him: to resonate with different levels of his "prenatal" being: his core-self as well as with his fear and the organismic representations of his pains and violations.

Since the resonance has to be not only psychological, but also somatic in nature, touch may be a very suitable means. The quality of touch on a prenatal level must be resonating and personal versus technical. It must express the intention of the therapist's body to symbolically be on the one hand the 'good womb' for the client and on the other hand to act as a safe companion through the jungle of frightening feelings and sensations.

On the one hand there is the need to reach and work through the high stress levels imprinted in the organism. On the other hand we need to offer a corrective tactile experience to the organism: While touching the therapist has to express that he resonates with the client (has a feeling contact with the client), that he is willing to open up to the client, is able to feel interested in his inner world, allows feelings of love towards him and that the therapist is willing to act as a container to the turmoil of feeling in the client. To achieve this we developed the Body Contact Method.

Offering Body Contact

The Body Contact Method is a specific technique of Psychodynamic Bodytherapy. In short it offers body contact at therapeutically well chosen moments with different parts of the body (e.g. belly to belly contact) or with the whole body. Ob-

viously the client must agree with this treatment. Timing is also essential. When applying this method, the therapist must be sensible and in contact to choose therapeutically right moments so that the client is not exposed to an incessant flood of stimuli that may re-traumatize him or her. 'Body Contact' is not technical by nature, but should always be applied according to the client's therapeutic needs, the life situation and the emotional capacity to integrate the experiences.

While being in body contact the therapist starts to synchronise his breathing with that of the client. Through this, organismic resonance is facilitated and the two separate bodies start to interconnect organismically.⁸ When working with this, the therapist sometimes feels like a container offering space and nurturing, protection and a non-invading environment. The therapist allows "to be used like air and water" (see Balint, 1997)⁹. Sometimes the therapist feels as if he contains and (obviously together with the client) works out negative contents detoxicating the client. Sometimes the therapist feels like having to provide oxygen into different parts of the body. Sometimes the therapist feels like working through layer-by-layer of fear, withdrawal, refusal, rejection, numbness and deadness to arrive at openness, deep relaxation, tranquillity, pleasure, centeredness and love. And at a deeply felt connection with ones own being and a deeply felt connection with the "world", with "everything" at the same time.

This work differs from regression work, though sometimes elements of regressive work may be involved. Regression work aims at reliving childhood experiences, at a (catharsic) release of feelings involved with it and an awareness of its inner conflict. Body Contact Work on prenatal levels does not aim at stimulating past experiences. Emotional expression of sadness or anger is not necessarily involved and full cognitive understanding of what is happening is mostly not achieved. Furthermore it is not a neurotic conflict we have to deal with. This is a category that demands an ego. We are not confronting a defence system in order to help the primary needs to appear. Instead of that we try to communicate a feeling of safety, continuity and resonance to build up something that will be an ego later on. (We call this function "Positivation"). We also follow and lead the client into his organismic dilemma¹⁰ (Mentzos: he uses the term 'dilemma' to describe the inner turmoil of the psychotic person, in contrast to conflicts we work on in neurotic processes), his fears and existential pains. Those are released primarily vegetatively through, for example, sweating, coughing, movement and sounds. They lead to processes experienced as opening up of emotional centres

⁸ "May it be clear how much this situation resembles the situation in the womb. Here too, establishment of contact takes place primarily on the energetic-bodily levels with the energy field of the mother's organism representing the holding environment in which the child can grow undisturbed." (I. Krens 1999, p. 42)

⁹ "... he must allow the patient to exist with him in a relationship, as if he is a part of his original substances. He must be prepared to carry the patient, not actively, but rather like water carries the swimmer or the ground provides a base for the walking person; in other words he must be there for the patient and be used by him, without too much resistance. ... However, the main importance is that he is there for the client, always reachable and undestroyable, just like water and earth." (Balint, 1997, p. 203)

¹⁰ Mentzos (1997) uses the term 'dilemma' to describe the inner turmoil of a psychotic person and separates it from the term 'conflict' that is connected to neurotic processes.

of the body like the heart, the belly, the upper back, the lower back and the head supporting experiences of self-contact.

This work is only possible if the therapist is genuinely able to open up to his or her organismic depth and to establish contact on a core-to-core level. This requires a high level of emotional maturity, organismic openness and receptivity.

It actually is very difficult to explain how we “do” Body Contact Work. It obviously is not ‘just a technique’ to apply. It asks for the personal and professional presence of the therapist, the capacity to resonate as well as psychotherapeutic skills. It is embedded in a psychotherapeutic process, in a psychotherapeutic relationship and in the adult life situation of the client.

Verbal and Psychodynamic Work to Deal with Resistance and to Address Adult Life Issues

We have to be aware that working on vegetative levels may sometimes bring up strong expressions of resistance, shame, fear, guilt and the tendency to acting out internalised prenatal death anxieties. The client can’t take “the good stuff” and will tend to create a situation that reduces or destroys the positive experience. First of all we encounter this resistance in the therapeutic relationship. Some clients will do anything to make it difficult for the therapist feeling warm and interested in them. They are actually busy symbolically aborting themselves. A lot of transference issues may occur: distrust, sexual feeling directed towards the therapist, falling in love with him or her, going beyond the personal limits of the therapist etc.

Furthermore, the therapist has to be alert concerning issues in the adult life of the client: his or her intimate relationships, the social and the work situation. Especially in a process when the client dares to open up to positive feelings there is a chance of this resulting in crisis or problem situations in his or her adult life as a symbolic repetition of prenatal learning and traumatisation. It is important to address these issues, the resistance and transference and to interpret them in relation to the prenatal themes dealt with on the organismic level.

Therefore Body Contact Work always needs its counterpart in verbal work on psychological and cognitive levels. The new experiences should to be placed in the context of the client’s life and also lead to profound change.

Allowing Feelings of Dependence

From a psychological point of view, the most important issue in working on prenatal bonding deficits is dependence.¹¹ Without any doubt issues of dependence will come up in the client. Feelings of dependence in general refer to bonding deficits in the pre- and postnatal developmental period. Those deriving from experiences in the womb are more intense and experienced as existential dilemmas of life and death.

When the longing to bond with the mother is severely deprived, dependence may be associated with alienation, extreme loneliness, invasion or disintegration.

¹¹ Issues around the symptoms, the dynamic and the therapeutic treatment of feelings of dependence have been described in detail in the following article: Inge Krens, 2000/2001.

A feeling of basic existential security is missing. This experience produces chronically high stress levels, because in the situation of absolute dependence at the beginning of life the individual is not able to survive without the other. For these clients the experience of dependence may be associated with death anxiety.

When working on severe prenatal bonding deficits we have to consider that the therapist is confronted with feelings of dependence. They have to be handled in the psychotherapeutic process in one way or another. The therapist, at least as long as he works psychodynamically, cannot avoid it: the client suffers so much of himself that he almost immediately projects his needs to depend on someone, on the therapist. To be forced to handle these intense needs can be very strenuous for the therapist and ask a lot of his time and energy. In times of crisis she has to be available even outside her office hours. The client has to be strengthened in the belief that she is connected to him via a long umbilical cord, even if he is desperate and in the turmoil of his feelings. To prevent overstrain and countertransference reactions of the therapist, there is the possibility to work together with one or more colleagues, to combine individual and group therapy, or in more severe cases to provide institutional care for a while. The important thing for the therapeutic team is to keep contact (feel attached with each other) and to offer the security of a stable relationship. They must symbolically serve as a “good” womb.

Autonomy issues of the client usually only become focus of the therapeutic interest when the unsatisfied need for dependence was worked on and trust as well as bonding abilities are developed. In less severe cases, e.g. clients with basically a neurotic structure, the work focusses on the balance and flexibility between feelings of dependence and independence, intimacy and autonomy. Both poles of the polarity are the issues. In any case, also for these clients feelings of dependence are not principally interpreted as therapeutically undesirable. They are seen as potentially hidden desires to attach to another person.

Positive Learning Experiences in the Womb

Prenatal experience is not something far away, something that has not anything to do with adult life. On the contrary: it is the basis of our life, it is the “source” of our emotional life. In a positive sense it reminds us of hope, connectedness and the wonder of life expressed in our bodies and souls. It gives a natural sense of belonging that reduces the general levels of anxiety, frustration and the impulse to attack others or oneself.

It affirms and intensifies the feelings of excitement and joy towards peace and ease with oneself and others and therefore reduces splitting tendencies and anti-social phenomena as: expulsion, exclusion, rejection, discrimination, functionalisation, interchangeability, and last but not least violence.

*held
wanted
protected
and contained
opening
pulsating*

*resonating
and bonding*

*I am
I feel myself through you
I am connected to all –
all is in me and with me.*

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